The Manifestation of Transference in the Formation of the Therapeutic Relationship

Catherine Tellides

Department of Educational and Counselling Psychology

McGill University, Montreal

November 2006

A thesis submitted to McGill University in partial fulfilment of the requirements of the degree of Doctor of Philosophy

Your file Votre référence
ISBN: 978-0-494-32247-5
Our file Notre référence
ISBN: 978-0-494-32247-5

Dedication

This dissertation is dedicated to my family.

I am deeply grateful to my parents, Michael and Soula Tellides and my brother, George Tellides, whose immense love and unconditional support have taught me that I am part of a greater whole in everything I undertake.

I thank my extended family for their love, dedication and generosity. My grandparents, Anargyros and Aikaterina Vouras and Giorgos and Theodora Tellides steamed across the Atlantic to offer us better opportunities than they had known. They nurtured a loving, supportive family and I am deeply grateful for every single member of my greater *oikogenia*: Uncle George and Aunt Carol Deros, Aunt Helen Sisto, my cousins Nickey and Aris Deros, Dora, Natacha and Andrew Sisto, and my sister-in-law Christina Mahmouridis.

Finally, I thank my husband, William B. Jaffee, Ph.D. - my new family - for his love, support and relentless encouragement. I have been blessed to learn first-hand that some family patterns really do repeat themselves.

Acknowledgments

My thesis advisor, Marilyn Fitzpatrick, Ph.D., has been a central figure in this work: She collected the session and interview data used in this dissertation, contributed to the conceptualization of the research and interpretation of findings, and helped edit this manuscript. I thank Dr. Fitzpatrick for her dedication to the completion of this dissertation and my doctoral degree. She has alternately been a wise mentor, stern thesis advisor and good friend, and I am grateful for all the roles she played in this process.

Martin Drapeau, Ph.D. contributed to the conceptualization of the research, provided training and guidance on the use of the CCRT instrument, verified the interpretation of findings, and helped edit this manuscript. Robert Bracewell, Ph.D. provided guidance on the methods of analysis used in the research, verified the results for accuracy, and confirmed the interpretation of findings. I thank Drs. Drapeau and Bracewell for their help, guidance and commitment to this work.

Jennifer Janzen, M.A. helped manage the data collection process and served as a CCRT rater with Alexia Jaouich M.A., Martha Chamodraka, M.A., and Nadia Marini, M.A. I am deeply indebted to them for completing this laborious task with enthusiasm and heart.

Over the years, several students in the Counselling Psychology program at McGill University have helped distribute, organize and code materials that were ultimately used in this dissertation. Although they are too many to name here, I thank these students for their contribution to this work. I am also grateful to Anastassios Stalikas, Ph.D., for accepting me as his student at the beginning of this degree, and setting in motion an enriching and satisfying process.

Contributions of Authors

Marilyn Fitzpatrick, Ph.D. served as the thesis advisor for this project. Dr. Fitzpatrick collected the psychotherapy session and interview data, and contributed to the conceptualization of both research studies, the interpretation of findings, and to the editing of both manuscripts.

Martin Drapeau, Ph.D. served as a thesis committee member for this project. Dr. Drapeau contributed to the conceptualization of both research studies, provided training on the CCRT instrument, offered guidance on the use of the CCRT in this research project, and verified the interpretation of findings.

Robert Bracewell, Ph.D. served as a thesis committee member for this project. Dr. Bracewell provided guidance on the method of data analysis, verified the analysis results for accuracy, and confirmed the interpretation of the results.

Jennifer Janzen, M.A., served as a CCRT rater and helped manage the data collection process.

Alexia Jaouich, M.A. served as a CCRT rater.

Martha Chamodraka, M.A. served as a CCRT rater.

Nadia Marini, M.A. served as a CCRT rater.

Table of Contents

List of Tables

Abstract

Across a number of theoretical orientations, the manifestation and working through of clients' central relationship patterns is considered to be an important aspect of psychotherapy process. The Core Conflictual Relationship Theme (CCRT) method was developed as an operationalization of transference, or the *transfer* of an individual's core relational schemas across relationships. Studies of therapeutic transference using pathological client samples have shown that there is some overlap between clients' relationship patterns with others and those that emerge with the therapist. The main objectives of the present research was to extend the study of therapeutic transference to therapies with high-functioning clients and to improve the methodology used in transference research by exploring an alternate method of collecting client narratives about their relationship with the therapist.

The first study explored the manifestation of transference with high-functioning clients in early sessions. Factor analyses of Wish (W), Response of Other (RO) and Response of Self (RS) components of the CCRT were conducted to examine the relationship between client relational themes with significant others and client relational themes with the therapist. Findings within the Wish (W) and Response of Other (RO) components indicated a complementary pattern of relating in which the therapist was idealized and others were devalued, and findings within the RS component indicated a concordant relational transfer, in which clients had a negative response to both the therapist and others. Additionally, control issues emerged in the W component for significant others and in the RS component for the therapist.

The second study addressed methodological limitations found in previous studies by drawing therapist narratives from a Participant Critical Event (PCE) interview rather than from psychotherapy sessions. In the PCE interview, client narratives about the therapist are not constrained by the presence of the therapist, resulting in a greater availability of potentially more candid descriptions of the therapeutic relationship. Factor analyses for the W and RO components indicated a complementary pattern of relating, in which the therapist was devalued and others were idealized, and findings for the RS component indicate a concordant relational transfer, in which clients felt bad with both the therapist and others. Additionally, the factor structure of the W and RO components suggests that as clients experience control issues with significant others, they wish to adopt a submissive stance toward the therapist.

Although both studies yielded a similar overall pattern of complementary and concordant transference, there was an inversion in the valence of the complementary transference; in the first study, therapists were idealized and significant others were devalued while in the second study, therapists were devalued and others were idealized. Since the source of therapist narratives was the single greatest methodological difference between the two studies, the inversion in the findings could reasonably be attributed to the source of therapist narratives. Taken together, the results of these two studies suggest that the source of relational narratives is an important consideration in the study of relationship patterns. Clinical and research implications are discussed.

Résumé

Parmi plusieurs orientations théoriques, la manifestation des modèles de relations interpersonnelles des clients est considéré comme un aspect important du processus de psychothérapie. La méthode « *Core Conflictual Relationship Theme* » (CCRT) fut développée comme un transfert opérationnel ou transfert des schémas relationnels d'un individu dans ses relations. Les études de transfert thérapeutique utilisant une population de clients pathologiques ont démontré qu'il y a un chevauchement entre les modèles de relations dans la vie quotidienne des clients et de celles qui émergent avec le thérapeute. Les objectifs principaux de cette recherche étaient de pousser plus loin l'étude du transfert thérapeutique aux thérapies de clients sans problème et d'améliorer la méthodologie utilisée dans la recherche du transfert en explorant une méthode alternative afin d'obtenir un rapport sur leurs expériences relationnelles avec le thérapeute.

La première étude a exploré la manifestation du transfert avec des clients sans problèmes significatifs. Les facteurs d'analyses des composantes du Souhait (W), de la Réponse de l'autre (RO) et de la Réponse de soi (RO) du CCRT suggèrent qu'un modèle complémentaire d'interaction, dans lequel le thérapeute est idéalisé et les autres sont dévalués, est présent. Les résultats des composantes du Souhait (W) et de la Réponse de soi (RS) indiquent un transfert complémentaire dans lequel le thérapeute est idéalisé et les autres sont dévalués. En ce qui a trait à la composante de la Réponse de soi, les facteurs indiquent un transfert relationnel dans lequel les clients ont un transfert négatif au thérapeute et aux autres. De plus, des problèmes de contrôle ont émergé dans la composante Souhait (W) pour les autres significatifs et dans la composante Réponse de soi (RS) pour le thérapeute.

La deuxième étude aborde les limites méthodologiques présentes dans les études précédentes en utilisant la méthode <*Participant Critical Event*> (PCE) pour recueillir les récits relationnels avec le thérapeute au lieu d'acquérir cette information via l'entretien thérapeutique. Dans l'entrevue PCE avec les clients, la présence du thérapeute n'a pas eue d'effet sur leur façon de décrire leurs expériences, ce qui a donné une description plus franche et naïve de leur relation thérapeutique. Les facteurs d'analyses des composantes de Souhait (W) et de la Réponse de soi (RO) du CCRT indiquent qu'un modèle complémentaire d'interaction, dans lequel le thérapeute était dévalué et les autres étaient idéalisés, est présent. Les analyses de la composante Réponse de soi (RS) indiquent un transfert relationnel concordant, dans lequel les clients ont un transfert négatif tant envers le thérapeute et qu'envers les autres. De plus, la structure du facteur des composantes W et RO suggère que, comme les clients éprouvent des problèmes de contrôle avec les autres significatifs, ils souhaitent adopter une attitude de soumission envers le thérapeute.

Bien que les deux études aient produit un modèle semblable de transfert complémentaire et concordant, une inversion dans la valence du transfert complémentaire est aussi apparente. Dans la première étude, les thérapeutes ont été idéalisés et les autres dévalués tandis que dans la deuxième étude, les thérapeutes ont été dévalués et les autres idéalisés. Puisque la source des récits relationnels avec les thérapeutes était la plus grande différence méthodologique entre les deux études, les conclusions inverses pourraient raisonnablement y être attribuées. Ensemble, les résultats de ces deux études suggèrent que la source de récits relationnels est une considération importante dans l'étude de modèles de relations interpersonnelles. Les implications clinique et de recherche sont discutées.

Introduction

Difficulties relating to others and the suffering associated with those difficulties are important reasons for why people seek psychotherapy (Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2004). Because the effectiveness of therapy appears to be strongly correlated to the therapeutic relationship (Horvath & Symonds, 1991; Martin, Garske, & Davis, 2000), the issue of how clients who have difficulty participating in relationships manage their relationships with their therapists is an important one.

Freud's (1909) notion of transference, or the "transfer" of an individual's core relational schemas across relationships, including the one with the therapist, is a key element of almost all psychodynamic and psychoanalytic therapies (Gelso, Hill, Mohr, Rochlen, & Zack, 1999). However, there is also strong evidence that transference plays an important role in non-analytic therapies (Gelso & Hayes, 1998). To help patients improve on their capacity to manage their own relationships, therapists across orientations often focus on the patients' relationships with significant others as well as the relationship that develops between patient and therapist (Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2004). A research-based understanding of these relationships is key to determining how they overlap and to what extent.

The *Core Conflictual Relationship Theme* (CCRT) method (Luborsky, 1977; Luborsky & Crits-Cristoph, 1990, 1998), a measure of the central relationship patterns, scripts, or schemas that individuals follow in relationships, has been used in the study of transference. The first study that set out to investigate the transference phenomenon (Fried, Crits-Christoph & Luborsky, 1992) used the original CCRT method to compare clients' in-session narratives about the therapist with clients' in-session descriptions of

general relationship patterns. This study demonstrated a modest parallel between the relationship themes drawn from narratives about significant others in patients' lives and themes drawn from narratives about the therapist.

Connolly and colleagues (1996) and Connolly, Crits-Christoph, Barber and Luborsky (2000) expanded on Fried and colleagues' (1992) work by examining the multiplicity of client relational themes about others and their relationship to themes told about the therapist. Both studies used the *Quantitative Assessment of Interpersonal Themes* (QUAINT) method (Crits-Christoph, Demorest, & Connolly, 1990) and had similar findings. The 1996 study found that for approximately 60% of the patients there was a significant correlation between themes for significant others and the therapist, and that for 34% of the patients the most pervasive theme for others correlated with the therapist theme. The 2000 study found a significant correlation between other and therapist themes for 50% of the patients, and a significant correlation between the most pervasive theme for others and the therapist theme for 33% of the patients.

The few CCRT transference studies conducted thus far appear to indicate an overlap between relationship patterns experienced with significant others and those experienced with the therapist. One feature common to all existing transference studies is the use of a clinical population, with established psychiatric diagnoses. Although there are mixed results concerning the link between severity of psychopathology and consistency of conflictual interpersonal themes (Cierpka et al., 1998; Wilczek et al., 2000), to date, no studies have explored transference with a high functioning population. Given the substantial number of high-functioning clients accessing psychotherapy services and the importance of preventative psychological care (Hunsley, Lee, & Aubry,

1999), it is necessary to develop an understanding of how an important therapeutic phenomenon, such as transference, develops in the therapies of a non-clinical population. One major objective of the current research is to expand the range of the population examined in transference research.

Another major purpose to this research is to add to the body of knowledge about therapeutic transference, while addressing some of the persistent limitations in existing research. Although each existing study built on and improved certain aspects of the methodology used in the study of transference, a number of limitations remain. These are: the use of unparallel data sources for narratives about significant others and about the therapist, the selection of participants based on their willingness to explore the therapeutic relationship with the therapist, and the lack of "high quality" therapist relationship episodes.

The use of a Participant Critical Event (PCE; Fitzpatrick & Chamodraka, submitted) interview as a source of narratives about significant events in the therapeutic relationship will enable researchers to equally invite all participants to discuss therapist interactions with an objective interviewer, provide participants a parallel opportunity in which to explore their relationship patterns with the therapist, and collect significant-event-focused "high-quality" therapist narratives.

The study of therapeutic transference is an important avenue of research, with far-reaching implications for clinical practice, research and training across several theoretical orientations. Two studies presented here will attempt to add to this important body of research. The first study will address the question: what is the relationship between client themes about significant others and client themes about the therapist in early therapy,

when the clients are high-functioning individuals. The second study will address the question: what is the relationship between client themes about significant others and client themes about the therapist in early therapy, when the clients are high-functioning individuals, and therapist themes are drawn from out-of-session guided interviews.

Both of these research questions were informed by a large body of theoretical and empirical work. The following sections will summarize that work in an effort to provide the reader with a comprehensive context for the current project.

Literature Review

Psychotherapy Process Research

The therapeutic endeavour generally occurs within a dyadic structure, and is designed to have a powerful influence on clients' lives. For almost six decades, psychotherapy researchers have sought to understand therapy process by exploring therapist contributions, client contributions, and client-therapist interactions that impact on both the process and outcome of therapy (Heppner, Kivlighan, & Wampold, 1999; Hill, 1990). At the foundation of this body of research lie two critical findings: (a) therapy is effective, and (b) therapies are equivalent.

Therapy is Effective

Psychotherapy clients show significant improvement over those in control conditions who have not been treated (Lambert et al., 1986; Luborsky, Crits-Christoph, Mintz, & Auerbach, 1988; Smith & Glass, 1977; Smith, Glass, & Miller, 1980). Research has shown that at the end of treatment, the average treated person is better off than 80% of an untreated sample (Smith et al., 1980). Furthermore, the road to recovery is not long

with 75% of clients improving after twenty-six sessions or six months of weekly therapy (Howard, Kopta, Krause, & Orlinsky, 1986; Kadera, Lambert, & Andrews, 1996). Many clients who undergo therapy also achieve a healthy adjustment for a long period, indicating that the results of therapy are well sustained over time (Nicholson & Berman, 1983).

Therapies are Equivalent

Research has also shown that, with few exceptions, different therapeutic approaches produce comparable therapeutic gains (Smith & Glass, 1977; Stiles, Shapiro, & Elliot, 1986). There is a general finding of no difference in outcome of therapy for clients participating in diverse therapies. We have known this since Smith and Glass' (1977) landmark meta analysis, but more recently, Elkin and colleagues (1989) and Imber and colleagues (1990) reported results from an NIMH study where 250 patients were separated into drug and clinical management, cognitive-behavioural therapy, and interpersonal psychotherapy groups. Three treatments were contrasted with drug placebo and a clinical management group. The results supported Smith and Glass' (1977) findings of equivalence across therapies.

Given that differing assumptions about change and techniques used to achieve change do not seem to significantly impact outcome, researchers have turned their attention towards factors common in all treatment modalities that may be responsible for general treatment effectiveness (Wampold, 2001). This "common factors" explanation has received much attention in psychotherapy process research (Reisner, 2005) and is the philosophical foundation for the current study.

Common Factors Research

Common factors in psychotherapy have been defined in a variety of ways. Castonguay (1993) summarized three definitions that emerge from the theoretical literature. Common factors can be seen as global aspects of therapy that are not specific to any one approach (common across approaches), such as insight, corrective emotional experiences, opportunity to express emotions, and acquisition of a sense of mastery. They can also be understood as aspects that are auxiliary to treatment and refer primarily to the interpersonal and social factors. This second meaning encompasses the therapeutic context and the therapeutic relationship. They may also be viewed as aspects of the treatment that influence outcomes but are not therapeutic activities or related to the interpersonal-social context (including client expectancies and involvement in the therapeutic process).These three broad classifications have been reiterated with some subtle variations by a number of theorists.

Lambert (1992) divided therapeutic factors into four broad areas and offered estimates of the degree to which each of these classes of variables contributes to outcome (estimates were not based on a statistical analysis). These four factors were: Client factors and extra-therapeutic events (thought to be responsible for 40% of therapy outcome variance), relationship factors (30%), expectancy and placebo effects (15%), and technique/model factors (15%). Goldfried (1991) proposed that all psychotherapies overlapped on a strategic level. These common strategies include: the expectation that therapy will help, the therapeutic relationship, obtaining an external perspective on oneself and the world, continued reality testing, and corrective experiences. Grencavage and Norcross (1990) performed a literature review and divided commonalities across psychotherapy modalities into five areas: client characteristics, therapist qualities, change

processes, treatment structures, and relationship elements. Lambert and Ogles (2004) grouped common factors into support, learning and action categories. Support includes aspects such as positive relationship, identification with the therapist, therapeutic alliance and trust. Learning includes aspects such as corrective emotional experience, exploration of internal frame of reference, cognitive learning and insight. Action includes aspects such as mastery efforts, working through, taking risks, and reality testing. The categories were selected to represent a developmental sequence assumed to emerge in psychotherapy process: supportive functions precede changes in beliefs and attitudes, which precede efforts to change client behaviour. Most recently, Bickman (2005) identified five broad categories of common factors determined by meta-analyses of therapy efficacy: client characteristics, therapist qualities, change processes, treatment structure, and therapeutic relationship.

Three areas of clear overlap emerge in all proposed conceptualizations of the common factors. These are: the therapeutic relationship, the impact of client contributions and treatment structures. If a clear understanding of psychotherapy process is to emerge, clinicians and researchers are advised to focus their attention on aspects of the process that mediate the establishment and maintenance of the common factors in a way that will shed light on the process as a whole (Carter, 2006; Gelso & Carter, 1994; Samstag, Muran, & Safran, 2004). Castonguay and Grosse Holtforth (2005) suggest that a separation of techniques from the therapeutic relationship in psychotherapy research creates a false dichotomy that will only serve to limit clinical application of findings. Techniques can never be offered in a context free of interpersonal meaning, and the impact of client contributions is only apparent within the interpersonal context of

psychotherapy (Beitman, 2005). In short, therapeutic models and their associated techniques constitute interpersonal events bound up in the expectations and beliefs and characteristics of the participants (Lambert & Bergin, 1994). Studies should attempt to incorporate and address as many of the therapeutic factor areas as possible because none of the areas are mutually exclusive as determinants of treatment outcome and the examination of any single aspect of psychotherapy as separate from other common factors is of limited value.

In the present research, a concerted effort is made to address and build on the findings of decades of psychotherapy research. Two primary common factors will be examined with the understanding that they are inextricably related to one another. These are: Client contributions and relationship factors.

Client Contributions

Based on a comprehensive review of the existing research, Lambert (1992) found that a considerable portion of improvement in clients' symptoms is attributable to client variables. There exists a virtually limitless array of client variables that can potentially influence therapeutic process and outcome (Clarkin & Levy, 2004). Research on client characteristics has addressed a broad variety of variables the client brings into therapy. Some of these include gender, social support, personality traits, motivation for change, and certain aspects of the individual's biological system. It is only reasonable to work from the premise that the nature of some problems and the makeup of some clients affect therapy outcome (Asay & Lambert, 1999; Beitman, 2005). The most challenging aspect of psychotherapy research is to select those variables that have proven most relevant to essential aspects of psychotherapeutic process (Clarkin & Levy, 2004).

Lambert (1992) suggests that some of the more important client variables that surface in the literature are capacity to relate, severity of disturbance, motivation, ego strength, psychological mindedness, and the ability to identify a focal problem. Among these, the client's capacity to relate with others stands out as one of the most frequently studied client factors (Luborsky, Barber, & Beutler, 1993) - a reasonable research focus given the interpersonal nature of the therapeutic endeavor.

Client interpersonal relatedness. Quality of relating has been defined in four general ways: (a) quality of relating to the therapist; (b) history of interpersonal relationships, (c) interpersonal functioning in current close relationships and (d) perceptions, beliefs, and wishes about relationships (Clarkin & Levy, 2004). There appears to be a distinct link between these aspects of client interpersonal relatedness and psychotherapy process and outcome. In a series of case studies, Strupp (1980) found that patients who did not improve in therapy did not relate well to the therapist and kept the interaction superficial, although the therapists were seen as having good interpersonal skills and their contribution remained constant throughout therapy. "These findings...run counter to the view that therapist-provided conditions are the necessary and sufficient conditions for therapeutic change...therapy can be beneficial provided the patient is willing and able to avail himself of its essential ingredients" (Strupp, 1980, p. 602).

In a qualitative study conducted by Hill, Nutt-Williams, Thompson, and Rhodes (1996), therapists were asked to recall impasses in long-term psychotherapy and suggest variables they believed were associated with those impasses. Among other contributing variables, therapists cited problems in the therapeutic relationship and the in-therapy

manifestation of obstructive client relational patterns as contributing to therapeutic impasses.

A number of researchers have also demonstrated significant relationships between the pattern of a client's interpersonal relationships outside of therapy and the therapeutic alliance that emerges during treatment (Couture et al., 2006; Luborsky, McLellan, Woody, O'Brien, & Auerbach, 1985; Marmar, Weiss, & Gaston, 1989; Kokotovic & Tracey, 1990; Piper, Azim, Joyce, & McCallum, 1991). The findings are somewhat mixed. Although some researchers found that good pretreatment interpersonal functioning was predictive of a positive therapeutic alliance (Moras & Strupp, 1982), others found that poor extra-therapeutic interpersonal functioning was linked to a more positive therapeutic relationship, specifically, the stronger the clients' conflict with a romantic partner, the better the alliance established with the therapist (Piper et al., 1991). Additionally, several studies have demonstrated that clients' capacity to engage in interpersonal relationships is predictive of therapeutic outcome, highlighting the overall importance of this client factor in the therapeutic endeavor (Alpher, Perfetto, & Strupp, 1990; Clementel-Jones, Malan, & Trauer, 1990; Connolly Gibbons et al., 2003).

Current empirical literature supports the notion that clients' extra-therapeutic interpersonal patterns have an influence on the therapeutic process, and more specifically on the therapeutic relationship (Bradley, Heim, & Westen, 2005). As previously mentioned, important client contributions to psychotherapeutic process and outcome, such as interpersonal relatedness, cannot be effectively examined independent of the interpersonal context in which they emerge.

Relationship Factors

The considerable research attention awarded to the therapeutic relationship is primarily due to consistent findings relating the working alliance to therapy outcome (Horvath & Symonds, 1991; Martin et al., 2000). For instance, a meta-analytic review by Martin and colleagues (2000) indicated that the overall relation of therapeutic alliance to outcome was moderate but consistent despite the presence of variables that are believed to mediate the relationship.

Much of the research on relationship factors began within the client-centered tradition that identified the "necessary and sufficient" conditions for client change (Asay & Lambert, 1999; Kirschenbaum, 2005). Rogerian conditions that overlap with the relationship factors described in the common factors approach include accurate empathy, positive regard, non-possessive warmth, and congruence or genuineness (Asay & Lambert, 1999; Kirschenbaum, 2005). Clinical wisdom and empirical evidence suggest that these, and related therapist relationship variables are fundamental in the formation of a therapeutic alliance and important for significant progress in therapy (Asay & Lambert, 1999; Lambert, 2005). Historically, much of the empirical work on the therapeutic alliance was generated by psychodynamic researchers, but lately, this area of research has received increased attention in studies of behavioral therapy (DeRubeis & Feely, 1991), cognitive therapy (Castonguay, Goldfried, Weiser, Raue, & Hays, 1996), and Gestalt therapy (Horvath & Greenberg, 1989). In so far as the therapeutic relationship is of substantial theoretical and empirical relevance across several theoretical orientations, it is necessary to examine how other important variables influencing psychotherapy, such as client interpersonal relatedness, impact this key phenomenon.

Summary

Client contributions in therapy such as the clients' ability to relate to others as well as their ability to engage in a relationship with the therapist have been shown to impact therapy process and outcome (Clarkin & Levy, 2004). Client contributions invariably exist within the context of the therapeutic relationship. A great emphasis has been placed on accruing information about the formation and development of the therapeutic alliance, which has been found to be the single variable most reliably associated to therapeutic outcome (Horvath and Symonds, 1991; Martin et al., 2001). As it is important to examine interdependent aspects of psychotherapy in tandem (Gelso & Carter, 1994; Safran, Muran, Samstag, &Wallner, 1994), it may be helpful to explore the impact of clients' general relational patterns on the therapeutic relationship.

The Manifestation of Client Relational Patterns in the Therapeutic Relationship

Many important events in life are interpersonal in nature. Difficulties relating to others and the associated suffering are important reasons for why people seek psychotherapy (Wilczek et al., 2004). There are very few human activities, including psychotherapy that cannot be adequately considered and defined from within an interpersonal model (Frances, 1996). As discussed, psychotherapy appears to involve at least two highly relevant and overlapping interpersonal models: One generated by the client-therapist interaction, and one pre-determined by the client's relational history. As the influence of the clients' relational history cannot be clearly separated from clients' perceptions of the therapeutic relationship, the two are intertwined and their area of overlap represents the clients' recreation of expectations, feelings, thoughts, and behaviours from past relational events in the current therapeutic relationship.

Dynamic Theories of Relationship Repetition

Freud observed a basic parallel in relationship patterns: soon after psychotherapy starts, the relationship pattern with the therapist is experienced as similar to the patient's early interactions with significant others. This observation gave rise to Freud's concept of a relationship template and to the term *transference*, a word that implies that there is a transfer of attitudes and behaviours from earlier relationships with personally important people to the later relationship with the therapist as well as others (Freud, 1909; Fried et al., 1992).

Since Freud, psychoanalytically-oriented theorists have discussed transference with considerable variability. Horney (1939) described transference patterns as *neurotic trends* and highlighted the normality of learning certain behaviours with significant others to satisfy basic needs. Sullivan (1953) described transference as a *parataxic distortion*, or the replay of idiosyncratic and subjective personifications of significant others with a new person. Klein (1952), Winnicott (1956) and Kohut (1968) addressed transference as a manifestation of early internalized object relations, with each suggesting a different emphasis on the self. Kohut (1968) also focused on specific transference reactions in narcissistic personality disorder and Kernberg (1987) identified transference patterns in borderline personality disorder.

Goldstein and Goldberg (2004) clarify the evolution of the conceptualization of transference by chronologically dividing it into two categories: the *old* definition and the *new* definition. The old model defines transference as a repetition of old conflicts in the present and the new model suggests that transference involves both old conflicts and new creations in the context of a real and unfolding relationship between two persons.

Control Mastery Theory (CMT; Weiss & Samson, 1986) is more closely affiliated to the *new* model of transference. It suggests that therapeutic transference can occur as a series of *tests*, in which clients attempt to rework relational conflicts by confronting therapists with attitudes and behaviors that have historically evoked a negative response in others. The *tests* are designed to determine whether the therapist will respond to the client with the same hostility received from significant others, thus the transference manifests itself in the context of a real and unfolding relationship between client and therapist (Weiss, 1994). One assumption of this framework is that clients express historically conflictual attitudes and behaviours in the safety of the therapeutic relationship that they may have learned to suppress with significant others. Thus, in contrast to more traditional notions of therapeutic transference that suggest a direct overlap between client patterns with significant others and the therapist, CMT suggests that therapeutic transference may manifest itself as client behaviors and attitudes that are quite different than those exhibited with significant others.

Regardless of its specific definition, transference is a key element of almost all psychodynamic and psychoanalytic therapies (Gelso et al., 1999), and plays an important role in non-analytic therapies as well (Gelso & Hayes, 1998).

Theories of Relationship Repetition

Cognitive theorists have also proposed that the client has underlying habitual patterns of thinking, or *schemata* (Beck, 1976; Hollon & Kriss, 1984), which serve to organize the client's experience, shape the perception and interpretation of events, and form the basis for individual instances of bias or distortion. Schemata thought to represent core cognitive conceptualizations are sometimes referred to as *core beliefs*. The

construct of interpersonal schemas plays a key role in explaining the phenomenon of transference in a way that is compatible with the language and research paradigms of cognitive psychology (Leising et al., 2003; Westen, 1991).

Within the constructivist tradition, Kelly's *Role Construct Repertory* (1955) is a method used to identify the main constructs a person uses for significant other people. Within this paradigm, the constructs people use for others are highly stable over time.

Tomkins' (1979) also proposed that individuals each have a "nuclear script" that is composed of a set of rules for understanding and dealing with the scenes of their lives. According to Tomkins, individuals tend to interpret present situations in terms of their similarity to childhood scenes (scenes are units that include persons, places, actions, and feelings).

Bruce Arnow's (2005) Cognitive Behavioural Analysis System of Psychotherapy (CBASP) conceptualizes depressed patients as having interpersonal difficulties that are likely to surface in the therapeutic relationship. The approach utilizes the therapeutic relationship to develop *transference hypotheses* used to guide cognitive restructuring and behavioural coping interventions for problematic interpersonal situations in patients' lives.

In fact, theorists across several orientations (e.g. Experiential: Greenberg, Rice, & Elliot, 1993; Cognitive-Interpersonal: Safran & Segal, 1990) focus on maladaptive representations of self and others formed in early relationships and their contribution to current states of distress and maladaptive interpersonal behaviour (Luborsky et al., 1985; Paivio & Bahr, 1998). Additionally, several theories espouse the view that some part of a conflictual pattern is generally outside of a person's awareness. Although these various

approaches use a differing vocabulary, theorists generally seem to agree that unrecognized assumptions become apparent to the client and therapist as they identify the consistencies or themes that run through the individual instances of upset (Freeman, Pretzer, Fleming, & Simon, 1990). Clients then begin to recognize situations in which these core beliefs are implicit in their reactions to potentially upsetting events, and can begin to consider an alternative inference.

While there are strong similarities across theories with respect to the role of client relational paradigms in the therapy process, there are also differences. For instance, cognitive-behavioral theorists emphasize clients' current relationships, whereas most psychodynamic theorists pay closer attention to the historical and potentially recursive nature of clients' relationship patterns (Horvath & Greenberg, 1994). Whatever the emphasis, more work is needed to establish the relation between that which occurs in the therapeutic relationship and both the client's early object relations and current interpersonal patterns (Horvath & Greenberg, 1994). This may be especially true for non-psychodynamic approaches to therapy, where very few researchers have focused their attention on interpersonal therapeutic processes (Crits-Christoph, 1998).

Summary

There is agreement among many schools of therapy that clients' relational patterns and current capacity to form a positive and productive relationship with the therapist interact in a way that is highly relevant to psychotherapy process and outcome. Clients who engage in psychotherapy often have interpersonal difficulties prior to the commencement of therapy that may impede the therapeutic process. There is abundant research support for the importance of clients' pre-existing interpersonal patterns in

psychotherapy process and outcome, despite varying operationalizations and diverse treatment approaches. The clinical implications are clear: Therapists must be experts in developing relationships with people who have difficulty doing so (Clarkin & Levy, 2004). The common factors perspective is the philosophical foundation of the present study, and the notion of transference is its theoretical foundation.

Research on Transference

Researchers in various realms of psychology have examined the concept of transference using a variety of methods and instruments. The following section will summarize some key methods and findings in this area of research.

In the experimental socio-cognitive realm of transference research (Andersen & Baum, 1994; Andersen & Cole, 1990; Andersen et al., 1996; Berk & Andersen, 2000; Hinkley & Andersen, 1996), individuals' idiosyncratic mental representations of significant others are accessed through sentence completion tasks, in which participants describe a significant other in terms unique to that person. Participants then take part in a laboratory experiment in which they are subjected to a number of statements about a new person. In one condition, the statements are designed to resemble the participants' earlier description of the significant other, and in another condition, they are designed to be discrepant. Following a brief distraction task, participants then complete a recognition-memory test, which is used to identify transference (i.e. representation-consistent inference and memory) between the significant other and the new person.

Findings from this area of research indicate that mental representations of significant others are activated and used to interpret other individuals in a "normal" (i.e. non-pathological; Andersen & Berk, 1998, p. 92) process of meaning making outside of

the psychotherapeutic context (Andersen & Baum, 1994; Andersen & Cole, 1990; Andersen et al., 1996; Hinkley & Andersen, 1996). Socio-cognitive studies have also shown that transference is more likely to occur when the new individual resembles a significant other along various dimensions, and less likely to occur when environmental cues and specific aspects of the new person are incongruent with mental representations relative to significant-others (Anderson & Cole, 1990; Anderson et al., 1995; Berk & Andersen, 2000).

In object-relations-based research, the *Montreal Transference and Countertransference Measure* (MTCM; Bouchard et al., 1997) has been used to examine transference along four theoretically-consistent dimensions: maturity of object relations, three manifest relationship situations (here-and-now, with an external object, and with a past object), allusions and displacements, and defensive turning of aggression against the self. In this framework, transference consists of here-and-now reactivations of past internalized object relations. Internalized object relations consist of fantasies involving a self representation, an object representation and the accompanying affects, wishes and desires (drive derivatives).

Using the MTCM method, significant units or figures are identified in a psychotherapy transcript and documented with minimal inference by an initial reader. A second reader interprets the units, and scores the MTCM along the four dimensions. Scoring is based on low-inference observable elements in the transcript. The measure yields a lengthy, clinically rich narrative of the transference, wherein researchers identify fluctuations in the actualization of modes of object relating throughout the treatment.

The *Psychotherapy Relationship Questionnaire* (PRQ; Westen, 2000) is a clinician-report measure designed to assess transference patterns in psychotherapy. The items included in the questionnaire measure thoughts, feelings, behaviors, motives, and conflicts expressed by the patients toward their therapists. Bradley and colleagues (2005) conducted a factor analysis on PRQ data and found five transference dimensions in the therapies of patients with a variety of Axis I and II diagnoses: angry/entitled, anxious/preoccupied, secure/engaged, avoidant/counter-dependent and sexualized. Because the PRQ captures therapist perceptions of patient responses to treatment, findings using the PRQ may be confounded by therapist countertransference.

The largest body of transference research involves the measurement of individual's central relationship patterns. In the early days of research on the therapeutic alliance, Lester Luborsky (1976) was intrigued by the connection between the "helping alliance" and the relationship patterns clients manifest with others in their lives. He asked: "How does the relationship pattern in the alliance fit into the broader central pattern of relationships?" (Luborsky, 1998, p. 3). This question spurred on the construction of a measure of central relationship patterns, the operationalization of Freud's concept of transference, and decades of research into clients' central relational schemas and their manifestation in the therapeutic encounter. Luborsky (1977) was the first to develop an objective measure of repetitive dysfunctional patterns of interpersonal behaviour. Since then, his CCRT method has become an internationally established, empirically-based approach for extracting client's central relationship patterns (Wilczek et al., 2004). It has yielded a growing body of clinically relevant findings that justify further study into core relational patterns (Albani et al., 2002). Luborsky's work paved

the way for the large variety of transference-related measures that exist today. The term "transference-related" is used to underscore the indirect measurement of the transference. The measures actually assess central conflictual relationship patterns that are assumed to reflect the transference. The actual transference is a complex construct that is not measured directly; it traditionally involves unconscious processes, implicates a number of internal states, requires the use of defense mechanisms, and is essentially an error in perception (Gelso, Hill, & Kivlighan, 1991).

Luborsky, Popp, and Barber (1994) identified fifteen approaches to measuring transference-related phenomena. Some of the more popular transference-related measures are: *Cyclic Maladaptive Patterns* (Strupp & Binder, 1984), *Role-Relationship Models Configuration* (Horowitz et al., 1991), *Structural Analysis of Social Behaviour* (SASB; Benjamin, 1974), Quantitative Assessment of Interpersonal Themes (QUAINT; Crits-Christoph et al., 1990), and Axis II of the *Operationalized Psychodynamic Diagnostics* (OPD; OPD Task Force, 2001) (Leising et al., 2003). These measures share a number of commonalities: (a) They are derived from a sample of relationship interactions drawn from psychotherapy sessions, guided interviews, or behavioural enactments of the client and therapist during a psychotherapy session, (b) they focus on the central or most pervasive relationship pattern across relational interactions, and (c) the data base is, at least partly, evaluated by clinical judgement rather than only by client self-report (Luborsky & Luborsky, 1995).

In a comparison of seven transference-related measures, Luborsky, Popp, and Barber (1994) noted that the two measures found to be most similar to the others were the CCRT and the *Structural Analysis of Social Behaviour- Cyclical Maladaptive Pattern*

(SASB-CMP; Schacht & Binder, 1982; Schacht &Henry, 1994). They also found that the CCRT, the SASB-CMP, and the *Consensual Response Psychodynamic Formulation* (CRPF; Horowitz, 1989; Horowitz et al., 1994) were most similar to each other and have the most reliably scoreable systems. The CCRT, SASB-CMP and the Plan Formulation in simplified form (PL; Weiss, Sampson, Caston, & Silberschatz, 1977, Weiss & Sampson, 1986) were found to be the least time consuming and most clinical-user friendly transference-related measures of the seven examined by Luborsky and colleagues (1994). Given that convergent validity, reliable scoring, time efficiency and clinical application are all important qualities to consider in a measure, the CCRT consistently emerges as one of the most useful transference-related instruments available today.

The Core Conflictual Relationship Theme (CCRT) Method

The *Core Conflictual Relationship Theme* (CCRT) (Luborsky, 1977; Luborsky & Crits-Christoph, 1990, 1998) is a central relationship pattern, script, or schema that every person follows in conducting relationships. It is derived from the narratives people tell and sometimes enact in the course of psychotherapy or from narratives shared in a guided interview. Related to the CCRT, the Relational Anecdotes Paradigm (RAP) interview was designed to serve as an alternate, potentially more versatile means of gathering relationship narratives that could be used for the same variety of purposes as the narratives drawn from psychotherapy sessions. Research has indicated that CCRTs drawn from RAP interviews are similar to those from psychotherapy sessions (Luborsky & Crits-Christoph, 1998).

Whether the narratives are drawn from within psychotherapy sessions or from an interview, the analysis is usually based on transcripts of those data. Although some

researchers have attempted to use actual recordings of psychotherapy sessions, rather than transcriptions of the recordings, they generally found that this approach took longer and did not yield better results. The net conclusion is that transcripts are "adequate and preferable for purposes of extracting the CCRT" (Luborsky, 1998, p. 17).

The CCRT method examines the consistencies that emerge across three recurrent aspects in clients' narratives of their interactions with others: The clients' wishes, needs and intentions (what the client wants); responses from other people (how other people react); and responses of the self (how the client reacts to others' reactions). The method involves the location and identification of a set of relationship episodes (i.e. explicit narrations about relationships with others, usually involving one main other person) and the extraction of the core conflictual relationship theme from those episodes. The core conflictual relationship theme consists of those Wishes (Ws), Responses of Other (ROs) and Responses of Self (RSs) that are most pervasive across relationship episodes.

Greater specificity in the categorization of the W, RO and RS components may be achieved by attending to the level of inference required for the W component and the valence and degree of expression of the RO and RS components. Wishes that are moderately inferable are rated as *W-inferred (W)* (Luborsky, 1998). Responses from other and responses from self are rated as either positive or negative from the perspective of the client. A negative response is one in which, from the client's perspective, there has been an interference with satisfaction of wishes. A positive response is one in which the client does not perceive an interference with the satisfaction of wishes or when the client experiences a sense of mastery in dealing with the wishes (Luborsky, 1998).

Responses of others are only scored when the other person in the relationship actually performed an action or expressed a response. If the client is only expecting a certain response from the other in the episode, these are scored as *RO-expected (ROE)*. Responses of self are further broken down into responses that are expressed and responses that are not expressed by the clients in the course of the episode they are describing. For instance, if a client stated: "I felt angry" in the narrative about an interaction with a significant other, it would be scored as a simple *RS*. If, however, the client stated: "I told him I was angry with him", it would be scored as *RS-expressed (RSE)*.CCRTs can be scored either with tailor-made formulations of Ws, ROs, and RSs or by using standard categories (Luborsky & Crits-Christoph, 1998). With tailor-made formulations, judges use their own language to describe the CCRT components in the relationship episodes. It is often the case that judges then translate that language into standard categories (Luborsky, 1998). To do so, judges must decide which of the standard Ws, ROs, and RSs most closely match the tailor-made formulations. Standard categories provide judges with a common language that has simplified quantitative comparisons of client CCRTs (Barber, Crits-Christoph, & Luborsky, 1998). A number of standard categories have been developed for use with the CCRT method, but five have received notable attention in CCRT research.

Edition 1 (Luborsky, 1985): This first set of standard categories, based on CCRT narratives from 16 outpatient psychotherapy cases consisted of 16 wishes, 16 ROs and 16 RSs (for a list of these standard categories, see Barber et al., 1998). Edition 1 of the standard categories was abstracted from judges' CCRT ratings of the sixteen patients and

the categories chosen were the ones that most frequently surfaced in the sample of narratives.

Edition 2 (Crits-Christoph & Demorest, 1988). This edition was created to provide a more representative collection of categories than were offered in the first edition. Representing a broad range of personality variables, this set includes approximately 30 categories for each CCRT component (for a list of these standard categories, see Barber et al., 1998).

Edition 3 (Barber, Crits-Christoph, & Luborsky, 1990, as cited in Luborksy & Crits-Christoph, 1998). Due to the large number of categories included in the second edition, this third edition was designed to reduce the list of standard categories to a more practical size. The categories in Edition 2 were divided into eight empirically-derived clusters of wishes, eight clusters of ROs and eight clusters of RSs (for a list of the clusters, see Barber et al., 1998). Because of their simplicity, these clusters are often used in CCRT-based research (E.g. Barber, Foltz, Crits-Christoph, & Diguer, 2002; Chance, Bakemann, Kaslow, Farber, & Burge-Callaway, 2000; Diguer et al., 2001; Wilczek et al., 2000).

Edition 4 (*Structural Analysis of Social Behaviour* (SASB); Benjamin, 1974). When researchers have perceived the need to have a more conceptually derived set of categories, they turned to Benjamin's SASB (1974) as another set of standard categories for CCRT scoring. Schacht, Binder, and Strupp (1984) have used the SASB categories in conjunction with the CCRT in the *Cyclical Maladaptive Pattern* (CMP) method.

Edition 5 (*Quantitative Assessment of Interpersonal Themes* (QUAINT) categories; Crits-Christoph et al., 1990). These categories rely on Benjamin's (1974)

SASB categories with the addition of a few new categories about affect. The categories are part of a system that is different from the usual CCRT method, in that all 104 categories are rated on a scale of 1-5 for the degree to which each is present in every relationship episode. A cluster analysis method helps determine whether there are multiple themes in each patient's narratives. The patient's narratives are rated one by one in random order.

Editions two and three have been used in conjunction with one another in several studies (Barber et al., 2002; Chance et al., 2000; Diguer et al., 2001; Drapeau & Perry, 2004; Drapeau, Roten, & Korner 2004; Wilczek et al., 2000), where the standard categories of edition 2 are used for scoring and the clusters developed in edition 3 are used as an overarching guide for scoring and as a means of reducing the number of standard categories used in the analyses (see Appendix A).

The CCRT is among the best- validated and most psychometrically sophisticated observer-based methods for assessing central relationship patterns (Barber et al., 2002). The method serves as a formalized and reliable system for generating the kind of inferences experienced clinicians make about clients' central relational patterns. It is a valid operationalization of the concept of transference, and was designed to facilitate scientific hypothesis-testing and the development of empirical findings regarding processes that may not be in clients' complete awareness. The next section will highlight some key findings generated by the CCRT measure and suggest the kind of work that is needed to build on the existing research.

Research Using the CCRT

Clinically, psychopathology is often associated with difficulties in close relationships (Wilczek et al., 2004). A number of research studies have also supported this association (Albani, Benninghoven, & Blaser, 1999; Cierpka et al., 1998; Diguer et al., 2001; Drapeau & Perry, 2004; Drapeau et al., 2004; Vanheule, Desmet, & Roseel, 2006). The maladaptive interpersonal schemas individuals employ in their relationships with others appear to be associated with the outcome of psychotherapy (Hoglend, 1993). Researchers using the CCRT method have found that the client's capacity to master maladaptive interpersonal patterns has some influence on the outcome of psychotherapy. Client symptoms were found to abate with the mastery of core interpersonal conflicts (Grenyer & Luborsky, 1996). Furthermore, interventions addressing core conflicts also support improved outcomes. The higher the convergence of therapists' interpretations with clients' core conflicting relationship themes, the more the client is seen to benefit (Luborsky & Crits-Christoph, 1988). This interaction between therapist interventions and client relational patterns emphasizes how crucial it is that clinicians develop an understanding of the manifestation and impact of client's core relational schemas in psychotherapy.

The CCRT method is also useful in guiding clinical formulations. One study examined whether the CCRT could equalize differences in therapist experience level in clinical formulation (Hori, Tsujikawa, & Ushijima, 1995, as cited in Luborsky et al., 1999). When experienced therapists were compared to therapists-in-training without the use of the CCRT, there were significant differences in the case formulations made by the two groups. However, when the CCRT frame was used to guide clinical formulations, the

experienced and inexperienced groups identified similar core conflicts, and arrived at less discrepant formulations. This study clearly demonstrates the function of the CCRT in guiding clinical formulations, and suggests the existence of strong clinical and training implications for all CCRT-based research.

The proper identification and use of core conflictual relationship themes in therapy appear to have a significant impact on clinical practice and therapy outcome. Empirical research thus far supports the relevance of examining the process and impact of clients' core relational schemas in psychotherapy, as measured by the CCRT. One important area of research for which the CCRT method has been used is that of therapeutic transference.

The CCRT Method in Empirical Investigations of the Transference Phenomenon

In an effort to help patients improve on their capacity to manage their relationships, therapists often focus on the patients' relationships with significant others as well as the relationship that develops between patient and therapist (Wilczek et al., 2004). For therapists to make proper use of the parallels in these relationships, it is necessary to gain an understanding of exactly how they overlap and to what extent. Given the theoretical and clinical importance of the concept of therapeutic transference, remarkably few studies have attempted to assess the consistency of interpersonal themes across different relationships (Barber et al., 2002), and even fewer have focused on evaluating the relation of clients' interpersonal themes outside of therapy to the relationship experienced with the therapist (Connolly et al., 2000). Studies that have examined the consistency of interpersonal narratives about individuals' relationships outside of therapy have not found strong support for the claim that the interpersonal

themes that compose a central relationship pattern are consistent across different relationships (Albani et al., 1994; Cierpka et al., 1998; Crits-Christoph & Luborsky, 1990; Crits-Christoph et al., 1990; Horowitz et al., 1991). So while theoretically transference is an important construct, there is still little support for the existence of a pervasive transference phenomenon.

Barber and colleagues (2002), whose own study on the consistency of interpersonal narratives yielded similar results, suggested two possible explanations. They proposed that it may be inappropriate to look for a transference that is reflected in all relationships and in all instances of these relationships. They suggest that future studies isolate the relationships that hold a particular relevance to an individual's core conflictual relational patterns and examine the consistency of the interpersonal narratives for those. Another major point they highlight is that most studies do not address the specific relationship with the therapist- the most clinically relevant aspect of the transference phenomenon. They suggest that the identification of a single, pervasive theme across all relationships may not be as important as the recognition of interpersonal themes observed in the therapeutic relationship that share some similarity with other relationships.

One recent study that attempted to draw a comparison between a therapeutic setting and clients' previous relationship patterns examined the extent to which patients in an inpatient clinic reenacted their experience and behaviour from relationships outside of therapy during their treatment (Stasch et al., 2002). In this study, patients' subjective relationship schemas, as related in the Relationship Anecdotes Paradigm (RAP) Interview and diagnosed according to the Operationalized Psychodynamic Diagnostics (OPD)

System at the beginning of treatment, were compared with the consensus rating of the team of therapists who assessed patients' interpersonal interactions and behaviour throughout the first three weeks of treatment. Results indicated that patients' past relational patterns corresponded with patient behaviours observed by the hospital team. While this study demonstrated that re-enactment of relationship-behaviour does occur, it did not explore the parallel between patient interactions with individuals outside of therapy and those that emerge specifically with the therapist.

Crits-Christoph and colleagues (1990) conducted a single case study in which they investigated a client's interpersonal themes over the course of psychotherapy. The CCRT method was used to score narratives derived from brief dynamic psychotherapy sessions. The findings revealed the presence of multiple relational themes, rather than a single pervasive theme across relationships. They also discovered that in the first half of therapy, the therapist was perceived as different from the others in the client's life. As therapy progressed, however, the similarities in the themes expressed by the client about the therapist and the significant others in his life increased. This would appear to indicate that as therapy progresses, there is potential for an increased intensity in the therapeutic transference.

In the following section, four studies that specifically attempt to explore the transference between therapist and client using CCRT-related measures will be summarized. Each study builds on the strengths of the previous one, while addressing certain of the methodological limitations.

Fried, Crits-Christoph and Luborsky (1992). The first study that set out to investigate the transference phenomenon (Fried, Crits-Christoph & Luborsky, 1992) used

the original CCRT method to compare clients' in-session narratives about the therapist with clients' general relationship patterns. The sample consisted of 35 participants engaged in dynamic psychotherapy, who told at least one narrative about their therapist during the therapy sessions. The patients had a variety of diagnoses. To obtain each patient's CCRT, ten relationship episodes about significant others were scored for three components: (a) The patient's main wishes, needs, or intentions towards the other person in the relationship episode, (b) the responses from the other person, and (c) the patient's own responses. The responses were further qualified as either positive or negative (seen by the patient as gratifying or not gratifying wishes). The most frequently found items in the ten relationship episodes constituted a preliminary CCRT. A final CCRT was formulated after repeated study of the session material. Because the patients related a very small number of therapist narratives in session (ranged from 1.6 for early sessions to 2.2 for late sessions), the researchers did not attempt to formulate a therapist CCRT based on these episodes. Instead, they had judges compare other-person CCRTs to the relationship episodes themselves.

Each judge read through the therapist relationship episodes and formed a "gestalt" or overall view of the patient through the repeated relationship themes expressed with the therapist. The judges then compared an overall view of the patient's theme with the therapist to the other-person CCRT for the same patient (matched) on a 1-7 "similarity scale" (1=no similarity, 7=high similarity). They also compared the therapist overall themes to the other-person CCRT formulations of seven randomly chosen (mismatched) cases. This matched-mismatched design was used to control for chance levels of similarity.

The correctly matched pairs of therapist episodes and other-person CCRTs were more similar than the average mismatched pairs, but the mean similarity rating for correctly matched pairs was only a modest $M = 3.5$, $SD = 1.0$. The authors hypothesized that cases with only one or two therapist relationship episodes did not offer adequate material for a proper therapist gestalt. When they tested this hypothesis, they found that cases with three and four relationship episodes most clearly showed the similarity between matched pairs of CCRTs and therapist relationship episodes for the wish and response of self components. A study of cases with more than three or four therapist relationship episodes did not reach statistical significance.

The authors noted that "it is difficult to talk to the therapist about the therapist" (p. 330), and suggested that patients may be more inclined to act out their feelings about the therapist, rather than actually discuss them.

The judges were also required to compare very different data sets. They were asked to determine the similarity between clear and brief descriptions of wishes and responses (CCRT formulations) and lengthy narratives (therapist relationship episodes). The authors suggested that future studies compare more similar items such as therapist CCRTs with other-person CCRTs. This would, however, require a change in the number, quality, or possibly the source of the therapist relationship episodes.

Connolly, Crits-Christoph, Demorest, Azarian, Muenz, and Chittams (1996). In the previous study, the judges who determined patients' CCRTs rated all narratives available in a transcript consecutively which may prompt a judge to see greater similarity in the relationship narratives than actually exists (Crits-Christoph et al., 1990). In response, Connolly and colleagues (1996) applied the *Quantitative Assessment of Interpersonal*

Themes (QUAINT) method (Crits-Christoph et al., 1990) to the narratives recounted by patients in psychotherapy. In this method, different narratives told by a single patient are randomly combined with the narratives from other patients. All narratives are then rated independently using a set of standard categories. Every single item in the set of standard categories for the Wish, Response of Others, and Response of Self components is applied to each randomly assigned narrative. Raters then rate the degree to which a certain item applies to a given narrative on a scale of 1-5. A cluster analysis of QUAINT profiles has also revealed multiple themes rather than a single pervasive theme for each patient (Crit-Christoph et al., 1990). Connolly and colleagues (1996) were interested in expanding on Fried and colleagues' (1992) investigation by examining the multiplicity of themes and their relation to narratives told about the therapist.

Twenty-one patients who had at least one relationship episode focusing on the therapist were selected for study. Many of the participants had concurrent diagnoses. Patients' interpersonal patterns were drawn from relationship episodes extracted from early psychotherapy sessions. An average of 3.8 sessions were rated across the sample and all rated sessions occurred between sessions one and ten of treatment. In relationship episodes about significant others (other than the therapist), the judges used the patient's narrative to extract the wishes and responses. In therapist relationship episodes, the judges used both narratives and the process of the in-session interaction inferred from the patients' verbalizations (also known as "enactments" of the relationship with the therapist) as a basis for scoring wishes and responses.

The 38-item QUAINT profiles for each patient's narratives were correlated and cluster-analyzed. This translated into a set of clusters for each patient. Each cluster had a

distinct relationship theme extracted from narratives about specific people in the patient's life. The results of this study revealed that for the majority of patients, more than one cluster emerged from the narratives, but all patients had at least one cluster that crossed different relationships. This indicates that patients display some similarity in interpersonal patterns across relationships although they will have several interpersonal themes.

For 60% of the patients there was a significant correlation between at least one cluster and the therapist profile. For 34 % of the patients, the most pervasive cluster correlated with the therapist profile. Also of interest was the finding that the correlations of the most predominant or "main" clusters with the therapist profiles were similar for cognitive and psychodynamic therapy.

In their discussion of the study's limitations, the authors comment on the specialized sample (opiate dependent patients) used for this study. They suggest that other therapeutic samples may reveal more therapeutic transference early in treatment. This investigation was also limited to early sessions of psychotherapy. Given that previous studies have shown that transference did not appear in initial sessions of therapy but did emerge later, Connolly and colleagues (1996) suggest that studies examine transference later in therapy. Finally, although the measurement used in this study was sensitive to explicit enactments of the transference that involved clients verbalizing their reactions to the therapist, it may have missed more subtle expressions of transference patterns in the therapeutic exchange- especially with patients who did not overtly discuss the therapeutic relationship with their therapist.

Connolly, Crits-Christoph, Barber and Luborsky (2000). The primary goal of this study was to attempt to disentangle the influence of the therapist in the overlap found between therapist relationship episodes and other-person episodes (Crits-Christoph, 1998). In this study, narratives about significant others were gathered from a pre-therapy interpersonal interview called the Relationship Anecdotes Paradigm (RAP; Luborsky, 1990) before the therapist met the patient. The patients' therapist narratives were drawn from three early and three late psychotherapy sessions. Included in the study were 18 patients with a primary diagnosis of major depression, who recounted at least one therapist relationship episode in the course of psychotherapy. Of those 18 patients, 11 recounted only one therapist narrative and the rest recounted between two or three therapist narratives. Both the pre-treatment interview narratives and the in-session therapist narratives were rated using the QUAINT system, as used in the Connolly and colleagues (1996) study.

Aside from disentangling the influence of the therapist by extracting relationship narratives prior to the beginning of therapy (where it is certain that the therapist has not influenced or encouraged the emergence of a relationship pattern), the authors of this study also aimed to overcome two other limitations apparent in previous transference studies. In both Connolly and colleagues (1996) and Fried and colleagues (1992), only narratives from early psychotherapy sessions were used. This focus on early sessions may underestimate the degree to which patients' relational patterns influence the therapeutic relationships across the course of therapy. In a single case study, Crits-Christoph and colleagues (1990) found that therapist narratives became more similar to other-person narratives later in treatment. Therefore, Connolly and colleagues (2000) decided to

compare the relationship between therapist narratives and other-person narratives in both early and late psychotherapy sessions.

Secondly, there appear to be large individual differences in the degree of therapeutic transference found in psychotherapy (Connolly et al., 1996). This finding suggests that there may be pre-treatment variables that can predict the amount of transference that emerges in psychotherapy narratives (Connolly et al., 2000). To address this question, Connolly and colleagues (2000) examined the relation of pre-treatment symptoms to the measure of therapeutic transference to explore for whom transference would emerge in the course of psychotherapy. Pre-treatment symptoms were measured using the *Beck Depression Inventory* (BDI; Beck, Ward, Mendelson, Mock, & Erlbaugh, 1961), the *Hamilton Rating Scale for Depression* (HRSD; Hamilton, 1960) and the *Health Sickness Rating Scale* (HSRS; Luborsky & Bachrach, 1974). The patients' quality of interpersonal relationships was assessed using a global rating of the HSRS (Luborsky & Bachrach, 1974).

Results concerning the degree of similarity between an other-person narrative cluster and the therapist thematic profile were remarkably similar to the Connolly and colleagues (1996) study. For 50% of the patients there was a significant correlation between at least one cluster profile and the therapist profile, with the most predominant or main cluster showing a significant correlation with the therapist profile for 33% of the patients.

Because similar results were obtained regardless of whether the relationship narratives were drawn from interviews prior to the beginning of therapy (safeguarded from the therapist's influence) or from within psychotherapy sessions (vulnerable to the

therapist's influence), the findings suggest that therapists do not elicit or *create* the relational themes in psychotherapy. Also, transference appears to be detectable in only half of all patients with the methods used in the last two studies. In the comparison of thematic clusters to therapist profiles across early and late psychotherapy sessions, the authors found that there was a significant correlation between the main cluster theme and an early session therapist theme for 27% of the patients, while 33% of patients revealed a significant correlation between the main cluster theme and a late session therapist theme. These findings indicated that transference did not manifest itself more clearly later in therapy, as previous research had suggested (Crits- Christoph et al., 1990).

A particularly interesting finding that emerged from this study involved how healthier patients revealed a greater overlap between the most pervasive theme in pre-treatment interviews and the theme that emerged in therapist narratives. Perhaps patients with more severe symptoms experience depression for reasons other than maladaptive interpersonal patterns, while repetition of maladaptive themes is more prevalent in those who are only moderately depressed.

Summary

Research has begun to suggest similarities between the patterns of relationship with the therapist and with others. Fried, Crits-Christoph, and Luborsky (1992) engaged in what they called the first empirical demonstration of transference in psychotherapy, providing evidence for the existence of a parallel between the relationship theme drawn from narratives about significant others in patients' lives and narratives about the therapist that emerged in psychotherapy sessions. Connolly and colleagues (1996, 2000) attempted to improve on the approaches used in previous investigations by allowing for

multiple themes across various significant others, examining both early and late sessions for transference, and examining narratives collected prior to the beginning of therapy to ensure that the therapist was not "creating" the themes evidenced in the sessions.

The CCRT transference studies conducted thus far have built on one another's methodology in a thoughtful and captivating manner. The emergent quality of the transference literature has prompted the current investigation to further explore the relation between clients' interpersonal patterns with the therapist and significant others, while addressing some of the persistent limitations outlined below.

Some Limitations of Existing Studies on Therapeutic Transference

The therapist is present during the patients' recounting of therapist narratives in psychotherapy, but the patients' significant others are not present during the recounting of those other-person narratives. Any empirical investigation that aims to use multiple perspectives must ensure that the various data sources are "parallel" or equivalent in fundamental ways. This is especially true in psychotherapy process research, where the subtlety of the therapeutic process is vulnerable to such details in data collection. In the previously described transference studies, patients' narratives about the therapist were compared to narratives about significant others in their lives. When patients shared relationship narratives about significant others to their therapist, the significant others were not present in the room, allowing for a freer exploration of those interactions. However when relationship narratives regarding the therapist were shared during the psychotherapy session, the other party involved (i.e. the therapist) was in the room, potentially limiting the clients' exploration and expression. "It is difficult to talk to the therapist about the therapist" (Fried et al., 1992, p.330).

One solution to this problem is to collect data about the therapeutic relationship in interviews, during which the therapist is not present. Thus far, the only CCRT study that directly compared relationship narratives drawn from psychotherapy sessions to those drawn from out-of-session interviews (Barber et al., 1995) did not explicitly target therapist narratives. In fact, the RAP protocol used in the collection of narratives excluded the therapist from a list of individuals the clients could discuss: "the other person might be anyone- your father, mother, brothers and sisters or other relatives, friends or people you work with" (Barber et al., 1995, p. 146). Thus, although results of this research indicate that data drawn from transcripts of early sessions is similar to data obtained by extra-therapy RAP interviews, the findings may not apply to therapist narratives. Rather, it is possible that interviews actually supply *clearer* relationship narratives pertaining to the therapist; While therapists are necessarily present during a psychotherapy session, they are not required for a RAP interview, allowing the client greater freedom of expression regarding their relationship with the therapist.

The RAP procedure can be varied so that any interview is potentially useful as a source of relationship narratives (Luborsky, 1998). Once the narratives have been located in the text of an interview, they can be scored as if they were elicited by a RAP interview (eg.Waldinger et al., 2002). The *Participant Critical Events* method (PCE; Fitzpatrick & Chamodraka, submitted) uses participant interviews to describe and identify events of therapeutic significance. The participants' description of events that took place in sessions and the taped sessions containing the events themselves are then available for further study. A semi-structured interview protocol allows for the collection of detailed descriptions of event sequences from both therapists and clients. The PCE interview is

similar to the RAP interview in its balance between open-ended and guided approaches to gathering information regarding a particular phenomenon. PCE interviews have been used to gather information regarding client perceptions of critical events in the formation of the therapeutic relationship (Fitzpatrick, Janzen, Chamodraka, & Park, 2006). While there is great similarity between the relationship narratives derived from RAP interviews and those derived using the PCE method, the PCE method offers the added benefit of locating therapist relationship episodes that were of particular salience to the client's perception of the therapeutic relationship.

The inclusion of participants on the basis of sharing at least one therapist narrative may be truncating the sample of patients used in the studies. A sample that is in some way systematically different from the larger group from which it is drawn is considered to be a biased sample (Heppner et al., 1999). If all members of the larger group do not have an equal chance of being selected, then those who are included in the sample do not properly represent the larger group. In all the transference studies reviewed, only patients who recounted at least one therapist relationship narrative in the course of their therapy were selected for study.

Because the samples were selected according to the inclusion of at least one therapist narrative in the psychotherapy sessions, they were actually studies of transference in the therapies of patients who were willing to discuss the therapeutic relationship with their therapist (i.e. the researchers were examining only the subset of the population that was willing to talk to the therapist about his/her relationship with the therapist). Connolly and colleagues (2000) admit to the possibility that the differences between the 18 patients who told a psychotherapy narrative about their therapist and the

rest of the sample could have biased their estimates of the transference. The most obvious practical consideration in a narrative-based study of transference is that researchers must have access to clients' narratives about their therapist. Therapist narratives are not, however, uniquely available in psychotherapy sessions. As previously mentioned, RAP interviews are designed to elicit relationship narratives, including ones about the therapist. An out-of-therapy interview is an excellent source of narratives in which all participants are equally invited to participate.

Therapist relationship episodes are scarce and the ones used are not necessarily clinically significant narratives about the therapeutic relationship. In CCRT studies examining therapeutic transference, a sufficient number of relationship episodes are needed to properly extract a relationship pattern both toward the therapist and toward other people. In all three studies, relationship episodes about other people were plentiful, whereas relationship episodes about the therapist were sparse. As a result, the patients' therapist profile was often determined from a single narrative about the therapist drawn from the psychotherapy sessions. In Connolly and colleagues (2000), for example, only one therapist relationship episode was used to determine the therapist profile for 11 of the 18 patients in the study.

Fried and colleagues (1992) found that cases with three and four therapist relationship episodes more clearly showed the similarity between other-person CCRTs and therapist relationship episodes than did cases containing fewer therapist relationship episodes. However, a study of cases containing more than 3 or 4 therapist relationship episodes did not reach statistical significance. Therefore, there does not appear to be a clear relationship between the number of therapist relationship episodes used and the

similarities found between general relationship themes and the relationships themes expressed about the therapist. An increased number of therapist relationship episodes may not necessarily improve the accuracy with which a therapist CCRT is determined.

Perhaps the emphasis in CCRT transference research should not be on the *number* of therapist relationship episodes, but rather on the *quality* of the episodes. The episodes provided by the clients within psychotherapy sessions, or even in the standard RAP interviews, are not necessarily particularly salient aspects of the therapeutic interaction. In session, clients spontaneously discuss some aspect of the relationship that emerges as relevant at that moment, and in the RAP interviews clients are asked to describe any interaction with the therapist that "was personally important or a problem to you in some way". The clients are not necessarily describing a significant event in the formation or development of the therapeutic relationship.

The study of significant therapeutic events has generally been seen as a promising avenue through which to investigate various forms of therapy process (Elliott, 1985; Gendlin, 1986; Hill & Corbett, 1993; Hill et al., 1988). In relation to the CCRT method, it would be beneficial to locate events that define the therapeutic relationship. Even if only one such episode is provided by the client, it will tend to highlight an interaction that is of critical importance to the relationship's development.

The *Participant Critical Event* (PCE) method (Fitzpatrick, Janzen, Chamodraka, & Park, 2006) focuses on significant events in therapy process using an interview designed to access a significant and defining event within the therapeutic relationship. Through this method, the client is asked to provide relationship narratives that adequately and succinctly capture their experience of the formation and development of the

relationship. With the use of focused therapist relationship episodes, researchers can be substantially more confident that they are constructing a therapist profile that reflects the client's relational pattern with the therapist.

The QUAINT system removes relationship episodes from their narrative context in a way that may reduce the clinical relevance of the CCRT method. Connolly and colleagues (1996, 2000) applied the *Quantitative Assessment of Interpersonal Themes* (QUAINT) method (Crits-Christoph et al., 1990) to the narratives recounted by patients in psychotherapy. In this method, different narratives told by a single patient are segmented and isolated from the other narratives. They are then randomly re-ordered and re-combined with the narratives from other patients, so that each patient's complete story is inaccessible to the rater. All narratives are then rated independently using a set of standard categories. Every single item in the set of standard categories for the Wish, Response of Others, and Response of Self components is applied to each randomly assigned narrative. Raters are required to rate the degree to which a certain item applies to a given narrative on a scale of 1 to 5. This system was proposed in order to allow for a more quantitative assessment of themes and the emergence of a profile of various content categories (versus only one or a few final themes as done with the CCRT method).

While there are certainly some clear benefits to developing a more rigorous method, such methodological improvements are sometimes made at the cost of relevance. Raters who have access to an entire transcript of a psychotherapy session are able to perceive the client's narratives in a way that is similar to how they are understood by the therapist during the session. This is a very important point, as the fundamental purpose of this research is to improve on clinical practice. Further, it is not clear as to why raters

should rate a relationship narrative on 5-point scale for *every single item*. Reliability statistics show that raters can reliably select the same category for a given item across all three components of the CCRT (wish, response of other and response of self) (Crits-Christoph, et al., 1988; Levine & Luborsky, 1981; Luborsky et al., 1986; Luborsky & Diguer, 1998). This means that raters are not, as the authors of the QUAINT method suggest, "missing something" by not rating the other categories (Fried et al., 1990).

Summary

The four limitations identified in the existing transference literature are: (a) therapist and other-person narratives do not represent parallel data points due to the therapist's presence during client narratives about the therapeutic relationship, (b) the inclusion of participants on the basis that they share at least one therapist narrative in front of the therapist creates a potentially biased sample of clients who are willing to do so, (c) the therapist relationship episodes culled from this psychotherapy sessions are not necessarily clinically significant narratives about the therapeutic relationship, and (d) the QUAINT system removes relationship episodes from their narrative context in a way that may reduce the clinical relevance of the CCRT method.

The second study of this dissertation addresses all four limitations by varying certain aspects of the methodology used to study transference. In addition to methodological issues, there are other variables that impact on the exploration of therapeutic transference including timing of observation, experience level of therapist participants, and level of functioning of client participants. These will be examined next.

Timing of the Exploration of Transference

Psychotherapeutic process can change considerably over the course of a therapy. It is important to take into consideration at which point we choose to examine it. For instance, researchers have found that the alliance is established within the first three sessions of therapy (Horvath & Symonds, 1991), and may be established as early as the first session (Sexton, Hembre, & Kvarme, 1996). By the third to fifth session, the quality of the therapeutic relationship is substantially reflective of the potential for future success (Horvath & Greenberg, 1994; Horvath & Bedi, 2002). In a seminal article on the patterns of interaction between transference and the alliance, Meissner (2001) suggests that transference and alliance are related constructs. As such, they may interact in oppositional ways as well as sustain and reinforce each other. He also states that some forms of transference may have significant overlap with alliance functions. If the first three sessions of therapy are critical to the formation of the alliance, and the alliance is intertwined with transference, it seems highly appropriate to explore transference in the early phase of therapy. Additionally, in a comparison of significant other thematic clusters to therapist profiles across early and late psychotherapy sessions, Connolly and colleagues' (2000) found that transference does not manifest itself significantly more clearly later in therapy, as previous research may have suggested (e.g. Crits-Christoph et al., 1990).

The Relevance of the Experience Level of Therapists

Although experienced and novice counsellors may conduct counselling in very different ways, some studies suggest that level of experience does not affect the therapeutic relationship, as rated by clients (Dunkle & Friedlander, 1996; Kivlighan,

Patton, & Foote, 1998). Additionally, CCRT research has shown that clients' core conflictual relational schemas do not appear to be significantly influenced by the therapist early in psychotherapy (Connolly et al., 2000), suggesting that therapist experience level may not interfere with the generalizability of the results to therapists with varying degrees of clinical experience.

On the other hand, there is some empirical support as well as a strong clinical wisdom that suggests that experience in the delivery of interventions can influence the alliance (Kivlighan et al., 1998). Because experienced and novice therapists attain similar alliance levels does not mean that the processes by which those alliances are created resemble one another. It may be best to extend the findings to therapists of a similar level of clinical experience or else to offer a cautious extension of the findings to other populations. The present research will examine therapeutic transference in the therapies of novice counselors.

Study of a High-Functioning Population

One feature of existing transference studies is the use of a clinical population, with established psychiatric diagnoses. In Fried and colleagues (1992), all 35 subjects were diagnosed according to the DSM III. Predominant diagnoses among this group were dysthymic disorder, generalized anxiety disorder, and a variety of personality disorders. In Connolly and colleagues (1996), the participants were 18 male opiate addicts many of whom had concurrent psychiatric diagnoses, and Connolly and colleagues (2000) included 18 participants with primary diagnosis of major depression, 30% of whom had a concurrent Axis II diagnosis. Yet, the majority of those who consult psychologists are relatively healthy, are of above average education and income, and do not have extensive

psychological difficulties (Hunsley et al., 1999). It is critical to develop research initiatives and clinical training that appropriately reflect the range of clients receiving services. The importance of examining therapy with a high-functioning clientele is especially relevant today, as preventative psychological care is increasingly recognized as a means of curtailing long-term health-care costs (Hunsley et al., 1999).

Given these realities, it is necessary to develop an understanding of how important therapeutic phenomena develop in the therapies of a non-clinical population. Although there are mixed results concerning the link between severity of psychopathology and consistency of conflictual interpersonal themes (Cierpka et al., 1998; Wilczek et al., 2000), to date, no studies have explored transference with a high functioning population. The current research will examine therapeutic transference in the therapies of relatively high-functioning clients.

The primary purpose of this research was to investigate the relationship between clients' general relationship patterns with significant people in their lives and the relationship patterns that emerge with the therapist. Two separate studies were conducted, each addressing a specific gap in the area of transference research. The first study explored the construct of therapeutic transference with high-functioning clients, a population that had not previously been studied in the transference literature. The second study utilized an alternate source for client narratives about the therapeutic relationship, aiming to improve on a number of methodological limitations associated with the customary use of psychotherapy sessions as a source of therapist narratives.

Running head: The Manifestation of Transference

The Manifestation of Transference in the Formation of the Therapeutic Relationship: Study of a High-Functioning Population

Catherine Tellides, M.Ed., Marilyn Fitzpatrick, Ph.D., Martin Drapeau Ph.D., Robert Bracewell, Ph.D., Jennifer Janzen, M.A., and Alexia Jaouich, M.A.

McGill University

The authors gratefully acknowledge the contribution of Martha Chamodraka, M.A., and Nadia Marini, M.A. for their assistance in data collection, and William B. Jaffee, Ph.D. for his assistance with the editing of this manuscript.

Correspondence concerning this article should be sent to Catherine Tellides, McLean Hospital, 115 Mill St., Belmont, MA 02478. ctellides@mclean.harvard.edu

Abstract

Despite the clinical use of therapeutic transference across various schools of psychotherapy, there have been relatively few empirical studies of this phenomenon none of which has examined transference with a non-pathological population. In this study, the *Core Conflictual Relationship Theme* method (CCRT) was used to examine the manifestation of therapeutic transference in the first three sessions of twenty-two (N = 22) therapies with high-functioning individuals. Factor analyses of the Wish (W) and Response of Other (RO) components of the CCRT indicate a complementary pattern of relating in which the therapist is idealized and others are devalued. Within the Response of Self (RS) component, clients exhibited a concordant relational transfer where they had a negative response to both the therapist and others. Additionally, control issues emerged in the W component for significant others and in the RS component for the therapist. Factor analysis of CCRT components provides a nuanced picture of transference development.

KEY WORDS: Therapeutic transference, relationship patterns, Core Conflictual Relationship Theme, CCRT

Many important life events are interpersonal in nature. Difficulties relating to others and the associated suffering are important reasons for why people seek psychotherapy (Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2004). Because the effectiveness of therapy appears to be related to the therapeutic relationship (Horvath and Symonds, 1991; Martin, Garske, & Davis, 2001), the issue of how clients who have difficulty participating in relationships manage the relationship with the therapist is an important one (Beitman, 2005).

Almost a century ago, Freud (1909) observed a basic parallel in relationship patterns; the relationship pattern with the therapist is experienced as similar to the patient's early relationship pattern with the parents. This observation gave rise to Freud's concept of *transference*, a word that implies that there is a transfer of attitudes and behaviour from earlier relationships with personally important people to the later relationship with the therapist and others (Freud, 1909; Fried, Crits-Christoph, & Luborsky, 1998). While transference is a key element in most psychodynamic therapies (Gelso, Hill, Mohr, Rochlen, & Zack, 1999), there is also evidence that transference plays an important role in non-analytic therapies (Arnow, 2005; Gelso & Hayes, 1998; Leising et al., 2003; Westen, 1991). Non-analytic concepts akin to transference include *role constructs* within the constructivist tradition (Kelly, 1955) and *schemata* and *core beliefs* in cognitive therapy (Beck, 1976; Hollon & Kriss, 1984). Experiential theorists such as Greenberg, Rice and Elliot (1993) and cognitive-interpersonal theorists such as Safran and Segal (1990) focus on maladaptive representations of self and others formed in early relationships and their contribution to current states of distress and maladaptive interpersonal behaviour (Luborsky et al., 1985; Paivio & Bahr, 1998).

In therapy, the identification of patterns in instances of upset can enable clients to consider alternative inferences (Freeman, Pretzer, Fleming, & Simon, 1990). To help patients improve on their capacity to manage relationships, therapists focus not only on relationships with significant others but also on the relationship that develops with them (Wilczek et al., 2004). An important research initiative is to gain an understanding of the unfolding of this parallel.

Transference Research

Transference research conducted in the experimental socio-cognitive realm indicates that mental representations of significant others are activated and used to interpret other individuals in a "normal" (i.e. non-pathological; Andersen & Berk, 1998, p. 92) process of meaning-making outside of the psychotherapeutic context (Andersen & Baum, 1994; Andersen & Cole, 1990; Andersen, Reznik, & Manzella, 1996; Hinkley & Andersen, 1996). Socio-cognitive studies have also shown that transference is more likely to occur when the new individual resembles a significant other along various dimensions, and less likely to occur when environmental cues and specific aspects of the new person are incongruent with mental representations relative to significant-others (Anderson & Cole, 1990; Anderson, Glassman, Chen, & Cole,1995; Berk & Andersen, 2000).

Psychotherapy researchers have also explored aspects of the transference construct using a great variety of methodological approaches. By far, the largest body of psychotherapy-based transference research involves the measurement of individual's central relationship patterns using the Core Conflictual Relationship Theme Method.

The Core Conflictual Relationship Theme Method

The Core Conflictual Relationship Theme (CCRT) Method (Luborsky, 1977; Luborsky & Crits-Christoph, 1990, 1998) is one of the earliest methods of narrative analysis in psychotherapy research (Diguer et al., 2001), and one of the foremost methods of studying therapeutic transference. Although other transference-related measures have been developed, the CCRT consistently demonstrates strong convergent validity, reliable scoring, time efficiency and usefulness in clinical application (Luborsky, Popp, & Barber, 1994). A core conflictual relationship theme is a central relationship pattern, script, or schema that an individual follows in conducting relationships. It can be derived from the relationship narratives clients typically tell and sometimes enact during a psychotherapy session or a guided interview. The CCRT method examines the consistencies that emerge across three recurrent aspects in clients' narratives of their interactions with others: wishes, needs and intentions (what the client wants); responses from other people (how other people react); and responses of the self (how the client reacts to others' reactions). The Wishes (W), Responses of Other (RO) and Responses of Self (RS) that are most pervasive across relationship episodes are frequently rated using a set of standard CCRT categories.

The CCRT has been used in the study of the influence of psychopathology on patients' difficulties in close relationships (Cierpka et al., 1998; Albani, Bennighoven, & Blaser, 1999; Diguer et al., 2001; Vanheule, Desmet, Rosseel, & Meganck, 2006; Wilczek et al., 2004), the convergence between therapist interventions and patients' core conflicting relationships (Luborsky & Crtits Christoph, 1988), and the impact of clients' mastery of core conflictual relationships on therapy outcome (Grenyer & Luborsky,

1996). Empirical research thus far supports the relevance of using the CCRT to examine the process and impact of clients' core relational schemas in psychotherapy. One important area of CCRT research is that of therapeutic transference. Yet, few CCRT studies have compared clients' interpersonal themes outside of therapy to the relationship experienced with the therapist (Barber, Foltz, DeRubeis, & Landis, 2002; Connolly, Crits-Christoph, Barber, & Luborsky, 2000).

The extant CCRT research on therapeutic transference has begun to suggest similarities between the patterns of relationship with the therapist and with others. In what they called "the first empirical demonstration of transference in psychotherapy" (p. 326), Fried and colleagues (1992) provided evidence for the existence of a modest parallel between the relationship theme drawn from narratives about significant others in patients' lives and narratives about the therapist that emerged in psychotherapy sessions. Connolly and colleagues (1996) and Connolly, Crits-Christoph, Barber, and Luborsky (2000) examined how a multiplicity of client relational themes about significant others were related to the themes about the therapist. The studies had similar findings. The 1996 study found that for approximately 60% of the patients there was a significant correlation between themes for significant others and the therapist, and that for 34% of the patients the most pervasive theme for others correlated with the therapist theme. The 2000 study found a significant correlation between other and therapist themes for 50% of the patients, and a significant correlation between the most pervasive theme for others and the therapist theme for 33% of the patients. These few studies indicate an overlap between relationship patterns experienced with significant others and those experienced with the therapist.

Clinical Samples in Research on Transference

Studies of transference in the realm of socio-cognitive psychology have found evidence that mental representations of significant others are activated and used to interpret other individuals in a "normal" (i.e. non-pathological; Andersen & Berk, 1998, p. 92) process of meaning-making outside of the psychotherapeutic context (Andersen & Baum, 1994; Andersen & Cole, 1990; Andersen et al., 1996; Hinkley & Andersen, 1996). However, all existing CCRT transference studies involve a clinical sample of participants, with established psychiatric diagnoses. In Fried, Crits-Christoph, and Luborsky (1992), all 35 subjects were diagnosed according to the DSM III. In Connolly and colleagues (1996), the participants were 18 male opiate addicts many of whom had concurrent psychiatric diagnoses, and Connolly and colleagues (2000) included 18 participants with a primary diagnosis of major depression, 30% of whom had a concurrent Axis II diagnosis. Yet, the majority of those who consult psychologists are relatively healthy, have above average education and income, and do not have extensive psychological difficulties (Hunsley, Lee, & Aubry, 1999). It is critical to develop research initiatives and clinical training that appropriately reflect the range of clients receiving services. Also, as preventative psychological care is increasingly recognized as a means of curtailing long-term health-care costs (Hunsley et al., 1999), it is becoming especially relevant to explore important therapeutic phenomena, such as transference, in a high-functioning population.

The current study was designed to investigate the relation between clients' interpersonal themes in sessions and the interpersonal theme verbalized in narratives about the therapist, using a high-functioning population in early therapy. The initial

sessions of psychotherapy were targeted because researchers have found that the alliance established within the first three sessions of therapy (Horvath & Symonds, 1991; Martin, Garske & Davis, 2000), perhaps as early as the first session (Sexton, Hembre, & Kvarme, 1996) is most strongly related to outcome. In a seminal article on the patterns of interaction between transference and the alliance, Meissner (2001) suggests that transference and alliance are related constructs. As such, they may interact in oppositional ways as well as sustain and reinforce each other, and some forms of transference may have significant overlap with alliance functions. If the first three sessions of therapy are critical to the formation of the alliance, and the alliance is intertwined with transference, it seems highly appropriate to explore transference in the early phase of therapy. Additionally, findings indicate that transference does not manifest itself significantly more clearly later in therapy (Connolly et al., 2000). This study will address the question of the relationship between client themes about significant others and client themes about the therapist in early therapy, with high-functioning individuals.

Method

Participants

Clients. Twenty-two clients (17 women and 5 men), ranging in age from 20 to 55 years (M = 30.19, SD = 11.47) participated in this study. They identified themselves as Caucasian (n = 7), European (n = 7), Other (n = 4), Asian-Canadian (n = 2), Middle-Eastern (n = 1), and Hispanic (n = 1). The clients were students enrolled in a counselling course in a human sciences program at a Canadian university. Their participation in

counselling was an optional experiential component of a course on counselling theory and practice.

Client presenting problems were identified using the *Target Complaints Scale* (Battle et al., 1966), which invites participants to specify three issues they would like to explore in therapy. Two advanced doctoral students then classified the clients' responses according to the *Taxonomy of Client Problems Seen in College and University Counselling Centers* (Candler & Gallagher, 1996). Seventeen of the 22 participants identified at least one target issue prior to the first therapy session. These were classified according to the taxonomy as follows: (a) Relationship difficulties 49%, (b) Self-Esteem 18%, (c) Academic concerns 7%, (d) Career concerns 7%, (e) Existential concerns 5%, (f) Eating disorder 5%, (g) Anxiety 5%, (h) Depression 2%, (i) Sexual abuse and harassment 2%. These responses indicate that clients were presenting with target complaints typically seen at university counselling centers.

Counsellors. Twenty counsellors (16 women and 4 men), ranging in age from 22 to 44 years (M = 30.19, SD = 11.47) participated in this study. They identified themselves as Caucasian (n = 14), European (n = 4), and Other (n = 2). The counsellors were first-year Master's students in counselling psychology completing a practicum. Their training followed an integrative, common factors philosophy informed by psychodynamic, cognitive-behavioral, humanistic, and process-experiential traditions. One counsellor saw three clients; the rest saw one client each.

Instruments

The Core Conflictual Relationship Theme (CCRT) Method (Luborsky, 1977; Luborsky & Crits-Christoph, 1998). The CCRT was used to assess client relationship

patterns. When using the CCRT, relationship patterns are typically determined from transcripts of narratives about interactions with other people shared by the client during psychotherapy sessions or an interview (Luborsky, 1998). The narratives are usually about a significant person in the patient's life- a parent, sibling, partner, friend or the therapist. Relationship narratives are assessed according to the following: the wishes, needs, and intentions of the client (W); the response of others to the client (RO); and the response of the client to others (RS).

CCRTs were scored with standard categories clustered into 8 W, 8 RO, and 8 RS clusters (Crits-Christoph & Demorest, 1988, as cited in Luborsky & Crits-Christoph, 1998). The clusters contain 35, 30 and 31 standard category items respectively and were used as a means of reducing the number of standard categories in the analyses (see Barber et al., 1998 for information on cluster derivation). These standard categories and clusters (see appendix A) were used in several other CCRT studies (e.g. Barber et al., 2002; Chance, Bakemann, Kaslow, Farber, & Burge-Callaway, 2000; Diguer et al., 2001; Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2000). They have been recommended in the CCRT manual as a "fairly comprehensive but still manageable list of categories to guide the judges" (Barber, Crits-Christoph, & Luborsky, 1998, p. 50).

There is good evidence for the reliability and validity of the CCRT (Barber et al., 2002; Crits-Christoph, Cooper, & Luborsky, 1988; Levine & Luborsky, 1981; Luborsky & Crits-Christoph, 1998; Luborsky, Crits-Christoph & Mellon, 1986; Luborsky & Diguer, 1998). The CCRT also has strong convergent validity with other transference-related measures such as the *Structural Analysis of Social Behavior- Cyclical Maladaptive Pattern* (SASB-CMP; Schacht & Binder, 1982; Schacht & Henry, 1994)

and the *Consensual Response Psychodynamic Formulation* (CRPF; Horowitz, 1989; Horowitz, 1994). The CCRT, however, has a more reliable scoring method and is considerably more time-efficient than similar measures (Luborsky et al., 1994).

Procedures

The data were drawn from the first three sessions of thirty psychotherapies. Of the thirty therapies, the twenty-two that contained at least ten client narratives about significant others (as suggested by Luborsky, 1998), and at least one client narrative about the therapist in the first three sessions of therapy were used. The sessions were transcribed, segmented into relationship narratives and rated using the CCRT method (Luborsky, 1977; Luborsky & Crits-Christoph, 1990, 1998).

Training process for CCRT rating. CCRT raters were four doctoral-level counselling psychology students. Each had experience with a variety of psychotherapy process rating systems as well as between two and five years of clinical experience. In accordance with guidelines for reducing bias associated with the use of non-participant judges (Heppner, Kivligan & Wampold, 1999), CCRT rater training consisted of a description of the CCRT method, discussion of sample items, rating of sample items, and monitoring of rater drift by verifying group consensus throughout the course of the rating task. Initially, raters were introduced to the CCRT method and rating system as well as the theory from which it was derived. All raters read Luborsky and Crits-Christoph's (1998) manual for the CCRT method. Raters were then trained by an expert CCRT researcher to locate, demarcate, segment, and rate relationship episodes from transcripts of Relationship Anecdote Paradigm (RAP) interviews. Because RAP interviews were designed to generate relationship narratives for use with the CCRT (Luborsky & Crits-

Christoph, 1998), they provide an excellent range of Ws, ROs, and RSs for training purposes. Raters segmented and rated each RAP interview transcript independently, then met to achieve consensus on the identification of the relationship episodes, the segmentation of the Ws, ROs and RSs within the episodes, and the ratings of the standard categories for each W, RO, and RS. The expert rater monitored the consensus meetings and answered questions related to the scoring process. Once raters demonstrated a strong understanding of RAP-based CCRT scoring to the expert rater, the same training procedure was repeated using sample psychotherapy sessions. When raters achieved adequate reliability on ratings for sample psychotherapy sessions (i.e. ICC (2,1) W= 0.98, RO= 0.95, and RS= 0.87; Drapeau & Perry, 2004, Drapeau, DeRoten, & Korner, 2004, Luborsky & Diguer, 1998, Luborsky et al., 2004), they proceeded to rate psychotherapy session transcripts designated for use in this study. Throughout the rating process, reliability checks consisted of comparing the ratings of two raters on twenty percent of the transcripts. Reliability checks never fell below acceptable levels (i.e. two consecutive ICCs below 0.70).

Data Analysis

Intraclass correlation coefficients (ICC) (Shrout & Fleiss, 1979) were used to determine interrater reliability on the CCRT clusters. To investigate the relationship between client relational themes about others and client relational themes about the therapist, exploratory factor analyses, using principle components analysis (PCA) were used to examine the structure of correlations among frequencies of Ws, ROs, and RSs in therapist and other-person narratives. The frequency counts of Ws ROs and RSs used in this study are the commonly used metric in CCRT research recommended by the

developers of the method (Luborsky & Crits-Christoph, 1998). Analyses were conducted at the level of clusters because the number of participants precluded an adequately powerful analysis of individual categories (Drapeau & Perry, 2004; Drapeau et al., 2004; Waldinger, Toth, & Gerber, 2001). Varimax rotation maximized the variance accounted for by each factor to facilitate interpretation of the factors (Field, 2005). The number of factors extracted for each component was based on inspection of the scree plot (Field, 2005) and on eigenvalues greater than one (Kaiser, 1960).

Stevens (1996) generally recommends interpreting factor loadings with an absolute value greater than 0.40, but cautions against interpreting factors without consideration of sample size. Upon examining the data and in consideration of the sample size in this study, factors were composed of items with loadings greater than or equal to an absolute value of 0.50. A more rigorous factor loading cut-off of 0.62 did not substantially alter the factor interpretation, indicating that items with loadings greater than 0.50 were of adequate substantive importance to each factor relative to sample size (Stevens, 1996). Additionally, MacCallum, Widaman, Zhang and Hong (1999) and MacCallum, Widaman, Preacher and Hong (2001) suggest that if communalities (i.e. the amount of variance a variable shares with all the other variables included in the analysis) are high (0.60 or higher), recovery of population factors in the sample data is normally very good, regardless of sample size. As mean communality values for the W, RO and RS components in this study were all above 0.60, the factors derived from this sample promise to be representative of factors in the sampled population. Separate factor analyses were conducted for the W, RO and RS clusters in order to examine how

relationship patterns emerge for each individual component, as well as across all three components.

Log transformations were performed on the data to reduce the impact of the outliers that skewed the distribution (Field, 2005). Clusters in which the data did not attain a normal distribution following the transformations (kurtosis>3.0 or <-3.0) were eliminated from the analysis (Field, 2005). All clusters endorsed by fewer than 30% of the subjects (W other-person $n = 4$, W therapist $n = 5$, RO other-person $n = 1$, RO therapist $n = 4$, RS other-person $n = 3$, RS therapist $n = 0$) were dropped from the analysis rather than folded into other clusters (as in Waldinger and Colleagues, 2001) in order to maintain the integrity of the statistically-derived clusters (Barber et al., 1990).

Pearson correlations between the transformed variables were compared to the results of the Principal Components Analysis (PCA), to determine the consistency of the data structure. A visual examination indicated substantial similarities between the data structure found in the correlations and the structure uncovered by the PCA, suggesting an acceptable reliability in the findings. The results of PCA analyses of the transformed W, RO and RS clusters were compared to results of PCA analyses of untransformed clusters to determine whether the log transformations had vastly altered the latent data structure of the correlations. Visual examination showed a similar data structure, indicating that the transformations did not substantially influence the latent factors uncovered in the factor analyses.

Results

Reliability

The median ICC (2,1) was 0.94 for the Wishes, 0.95 for the Responses of Other, and 0.87 for the Responses of Self, indicating acceptable reliability of the ratings. The range of the ICCs was 0.77- 1.00 for the wishes, 0.76- 1.00 for the responses of other, and 0.49- 0.98 for the responses of self.

Descriptives

The means and standard deviations and range of the variables included in the analyses for the W, RO and RS components are included in Table 1. The mean number of therapist relationship episodes included in the analyses was 2.35 (*Mdn* = 2), and the mean number of significant-other relationship episodes included in the analyses was 15.70 (*Mdn* = 13.5).

Therapist and Other Wish Clusters

The Wish clusters retained for analysis in the current study were: Other-person clusters 1, 2, 3, 5, 6, 7, 8 and therapist clusters 5, 6, 8. (see Table 2 for cluster names). Four wish factors were extracted, accounting for 69.11% of the total variance of the ten clusters included in the analysis. Varimax-rotated factor loadings are shown in Table 2. Three items loaded heavily on Factor 1 (19.16% of the variance), named *Wish To Be Loved and Understood By The Therapist, Not By Others*. This factor was characterized by items indicating a wish to help, achieve and be loved and understood by the therapist and an absence of the wish to be loved and understood by others. Three items had high loadings on Factor 2 (18.14% of the variance), named *Wish To Be Submissive With Others.* This factor was marked by items indicating a desire to yield to others in the

service of preserving closeness and comfort. The third factor, *Wish To Dominate Others*, marked by items describing a desire to assert self and control others (17.04% of the variance) and fourth factor *Wish To Focus Help on Others* (14.77% of the variance), marked by items indicating a wish to help others but avoid involvement with the therapist each had high loadings on two items.

Therapist and Other RO Clusters

The Response of Other clusters retained for analysis were: Other-person clusters 1, 2, 3, 4, 5, 7 and therapist clusters 1, 5, 6, 7, 8 (see Table 3 for cluster names). Four RO factors were extracted, accounting for 71.39% of the total variance of the eleven clusters. Varimax-rotated factor loadings are shown in Table 3. Four items loaded heavily on Factor 1, named *Others Are Rejecting And Opposing, Therapist Is Not* (24.99% of the variance). This factor included items indicating that others were powerful and rejecting and opposing, but the therapist was not rejecting and opposing. Three items loaded heavily on Factor 2, titled *Positive Response From Therapist* (18.58% of the variance) and included items suggesting the therapist was helpful, understanding, and liked the client. Factor 3, *Ambivalent Response From Others* (14.94% of the variance), marked by the perception of others as being both bad and agreeable, and Factor 4 *Others Are Upset, Therapist Is Strong* (12.88% of the variance), marked by items indicating others are upset and the therapist is strong, each loaded heavily on two items.

Therapist and Other RS Clusters

Thirteen Response of Self clusters were retained for analysis: Other-person clusters 2, 3, 4, 6, 8 and therapist clusters 1, 2, 3, 4, 5, 6, 7, 8 (see Table 4 for cluster names). Four RS factors were extracted, accounting for 66.81% of the total variance of

the thirteen clusters. Varimax-rotated factor loadings are shown in Table 4. Three items loaded heavily on Factor 1, named *Negative/Passive Response to Others* (18.09% of the variance). This factor was characterized by items indicating the client was anxious, ashamed, unreceptive and helpless with others. Four items loaded heavily on Factor 2, *Control Issues With Therapist, Not With Others* (17.12% of the variance), which included items indicating both self-assertion and powerlessness with the therapist and an absence of self-assertion with others. Three items had high loadings on Factor 3, *Ambivalent Response To Therapist* (17.10% of the variance), marked by items suggesting both an approach toward and avoidance of the therapist. The fourth factor, *Feel Bad With Others, Feel Bad With Therapist* (14.50% of the variance) had high loadings on three items that indicated anxious and depressed responses to the therapist and an absence of feeling respected and accepted with others.

Discussion

The primary goal of this study was to examine the transfer of relationship patterns between significant others and the therapist in the early therapy sessions of a high functioning population. Findings within the W and RO components indicate a complementary pattern of relating in which the therapist is idealized and others are devalued, and findings within the RS component indicate a concordant relational transfer, in which clients have a negative response to both the therapist and others. Additionally, control issues emerged in the W component for significant others and in the RS component for the therapist.

Traditionally, transference phenomena have been viewed as "repetitions and not new creations" (Freud, 1936/1990, p.111), and previous empirical studies of transference

have tended to support that view (Connolly et al., 1996, 2000). The results of the present study illustrate a somewhat different scenario among high-functioning clients and therapists-in-training early in treatment. These findings can be interpreted from a core conflicts and patterns perspective (Drapeau & Perry, 2004, Drapeau et al., 2004), using three conceptual frameworks: The cross-theoretical concepts of *concordance* and *complementarity*; the psychoanalytic construct of *splitting*; and the systems-derived *triangulation* paradigm.

Theorists and researchers of various psychotherapeutic orientations (e.g. psychoanalytic: Mermelstein, 2000 & Racker, 1968; cognitive: Festinger, 1957; constructivist: Kelly, 1955) posit that relational experience is shaped by the organizing principles of sameness and difference, and that relationships, including ones with therapists, can be understood within a framework of concordance (sameness) and complementarity (difference). Generally, the concepts of concordance and complementarity are used to explain how individuals strengthen their sense of self relative to another person, but they can also be useful in understanding how individuals organize their experience of two or more separate objects (Soldz, 1993). In the present study, the clients' wish to be loved and understood by the therapist is closely linked to the absence of that wish with regard to significant others (Wish To Be Loved and Understood By The Therapist, Not By Others). Similarly, when clients view significant others as rejecting and opposing, they do not view the therapist that way (Others Are Rejecting And Opposing, Therapist Is Not). According to principles of differentiation, these dichotomous contrasts are made in the service of organizing clients' new relational experience with the therapist in context of existing relationships. The process of

assimilating experience necessarily involves "straddling the space between the opposites" (Benjamin, 1995, p.125). The sharp distinctions clients make between the therapist and significant others in these early sessions may be a necessary step in the development of a sense of internal consistency (wholeness and stability), in the face of external contradictions.

Within the psychoanalytic frame, the dichotomous organization of others into good and bad objects, referred to as *splitting,* is designed to protect an individual against thoughts and feelings that are experienced as threatening in their contradiction (Schneider, 2003). In so far as splitting is conceptualized as a protection against threat, it may be viewed as either an unhealthy defense used to create an artificial and robust separation between two contradictory elements (Klein, 1946/ 1975), or a healthy means of organizing experience in preparation for the integration of disparate elements (Schneider, 2003). Schneider (2003) proposes that because of its polarizing effect, splitting creates a "generative space" in which contrasting elements can be brought together in imagination (p. 33). Taken as a preparatory process toward assimilation of experience, rather than a pathological defense antithetical to integration, the splitting evidenced in these therapies of high-functioning college students (i.e. idealization of therapist, devaluation of others) may be demonstrating a desire to create order and safety in their lives, particularly at the beginning of new and potentially disorienting therapeutic encounters.

The splitting evidenced in these therapies may also be understood in terms of a triangulation dynamic between client, therapist, and significant others. Both splitting and triangulation are attempts to master ambivalence (Juni, 1995), which appears to surface in

the findings for the W and RO components. Clients have contradictory wishes to be submissive to (Wish To Be Submissive With Others) and dominate others (Wish To Dominate Others), and experience others' responses to them as ambivalent (Ambivalent Response From Others). This ambivalence with regard to significant others may be unsettling enough to clients that they need to use triangulation to maintain homeostasis by shifting the unstable relationship with others into a stable triad with the therapist (Juni, 1995). Within this dynamic, therapists are not valued so much for themselves but for the function they serve as a repository of transferential affect from the dyad, which cannot be affectively elaborated at its source (Juni, 1995). This may explain why clients' response to the therapist is ambivalent and laden with conflicts around control (Control Issues With Therapist, Not Others and Ambivalent Response To Therapist), even though their ambivalence about dominance and submission primarily revolves around significant others (Wish To Be Submissive With Others and Wish To Dominate Others). Clients perceive the therapeutic situation as less threatening than their relationships with significant others (Others Are Rejecting and Opposing, Therapist Is Not, Positive Response From The Therapist, Ambivalent Response From Other, Others Are Upset, Therapist Is Strong). Therefore, they remain passive towards others (Negative/Passive Response To Others) and address control issues with the therapist (Control Issues With The Therapist, Not Others).

There is one area in which the findings indicate a concordant relational dynamic, the traditional idea of transference, expressed across significant others and the therapist: Within the Responses of Self component, the clients' feel badly with both the therapist and significant others (Feel Bad With Others, Feel Bad With Therapist). However this

factor captures more than mere concordance between the therapist and others. Close examination of the therapist and other clusters included in the Feel Bad With Others, Feel Bad With Therapist factor indicates that clients feel bad in different ways. Clients feel anxious and ashamed with the therapist and do not feel respected and accepted with others. This finding may be interpreted in a variety of ways.

One explanation for the grouping of these two clusters is that clients may experience anxiety, shame, disappointment and depression when they feel unable to tell an idealized therapist (idealization observed in Wish To Be Loved And Understood By Therapist, Not Others, Others Are Rejecting And Opposing, Therapist Is Not, and Others Are Upset, Therapist Is Strong) that they feel accepted and respected with others. Interpreted in context of other RS factors, we suggest that part of the work of therapy involves *working through* control issues with a therapist (Control Issues With Therapist, Not Others), even though clients may still respond passively (Negative/Passive Response To Others) to those with whom they have a previously established ambivalence (Wish to Be Submissive With Others, Wish To Dominate Others). Early in the process, this contrast may create feelings of anxiety, shame, disappointment and depression with regard to the therapist and a perceived lack of respect and acceptance from others.

Although the subtle differences in how the clients feel bad with the therapist and others are informative, it is also important to consider that the clients are, in fact, having a negative response to both the therapist and others in this factor. In tandem with the splitting witnessed in the W and RO components, the concordance across both relationships in the RS component may be understood as a move towards the consolidation of clients' contradictory experiences of the therapist and significant others.

Limitations

There are several limitations to the present study: the specificity of the participant sample, the small sample size, and the focus on early therapy sessions will be discussed. The absence of concordant relational patterns for therapists and significant others across all three CCRT components is different from results of previous CCRT transference studies using a pathological population (Fried et al., 1992, Connolly et al., 1996, 2000). It is difficult to determine whether this supports the link between severity of psychopathology and consistency of conflictual interpersonal themes (Cierpka et al., 1998; Wilczek et al., 2000), as there is no clinical comparison point within the present study.

The therapist participants in this study were counsellors-in-training and their inexperience may have had an impact on the development of transference in early therapy. Some studies suggest that level of experience does not affect the therapeutic relationship as rated by clients (Dunkle & Friedlander, 1996; Kivlighan, Patton, & Foote, 1998), while others indicate that experience in the delivery of interventions can influence the therapeutic relationship (Kivlighan, Patton & Foote, 1998). While evidence to date suggests that clients' core conflictual relational schemas are not significantly influenced by the therapist in early psychotherapy (Connolly et al., 2000), we do not how therapist inexperience may have contributed to these findings.

The clients involved in the study participated in counselling as an optional component of a counselling course. They identified presenting problems typical of those seen in a university counseling center (see *Target Complaints* information in method section), and as such, may not represent the average high-functioning adults who seek

therapy for mild to moderate psychological discomfort. Clients in this study were *offered* psychological treatment and although they willingly participated, the nature of the arrangement may have influenced findings - especially with regard to the emergence of control issues early in the therapeutic relationship. Caution should be used in generalizing the results of this study to the therapies of other high-functioning individuals who initiate treatment independently.

Additionally, because the client participants were students in a human sciences program, they may have been predisposed to helping others. W factor 4, Wish To Focus Help On Others, may be an artifact of this sample. The clients' orientation to helping others may have encouraged their identification with the therapist as a helper, and reduced their interest in being open with (and thus helped by) the therapist.

Another limitation of this research involves the relatively small sample used in the factor analysis of this data. In factor analysis, the stability of the factor structure is contingent on the sample size. The addition of more data may cause variables to switch from one factor to another (Guadagnoli & Velicer, 1988). Although mean communalities above 0.60 indicate that the same factors are likely to be found in the population (MacCallum et al., 2001), it is possible that a larger sample may have suggested a different factor structure and consequently a different perspective on the manifestation of transference in early therapy.

It is also important to underscore that this was a study of early psychotherapy sessions, and consequently, the early manifestation of transference. As such, findings of complementary transference and splitting between the objects of the therapist and

significant others may be an initial phase in the development of a more concordant transference later in treatment.

Contributions

From a research perspective, factor analysis of the relationship between therapist and significant other CCRT components appears to facilitate a more nuanced interpretation of how transference manifests itself. The factor structure facilitates an exploration of both concordant (i.e. overlapping, congruent) and complementary (i.e. opposing, incongruous) relationship patterns across any number of therapist and significant other clusters. The approach illuminates not only whether or not transference exists in a theoretically-consistent manner (Ekstrom, 2002), but also *how* transference manifests itself in therapy. The specificity of these findings is potentially more informative to clinical practice than knowledge of whether or not concordant transference patterns emerge in the therapeutic relationship.

Clinically, the findings from this study suggest that therapist attention to complementary transference patterns, in addition to traditionally- prescribed concordant transference patterns may improve therapists' understanding of the early dynamics of treatment with high-functioning clients. A nuanced understanding of the therapeutic idealization that emerges early in treatment could more accurately inform case conceptualization and treatment interventions. The findings also indicate that it may be helpful for clinicians to carefully monitor the manifestation of control issues within a dynamic of complementary transference, as this appears to be related to client feelings of anxiety and shame in early treatment. Although therapists of various orientations will utilize and manage the concept of complementary transference differently, careful

attention to clients' internal struggle to organize relational experience is likely to enhance therapist effectiveness, regardless of clinical approach.

Future Research Directions

Further CCRT research is necessary to determine the impact of the specificity of the participant sample, the small sample size, and the focus on early therapy sessions. Future CCRT transference studies that compare the factor structure of W, RO and RS components across high-functioning and pathological client populations could help distinguish population differences in the manifestation of transference. The findings of the present study should also be verified using more experienced therapists and clients who have independently initiated treatment in order to determine whether the specificity of the sample significantly impacted the results. Additionally, a replication of this research across the course of therapy would elucidate the impact of timing on the manifestation of transference. Finally, replication of these results using a larger sample would support the validity of these findings.

Conclusion

Transference plays a central role across several therapeutic orientations. It offers therapists a template for understanding clients' relational difficulties and a conceptual bridge between clients' experience of the outside world and their involvement in the therapeutic process. Psychotherapy researchers must continue to explore this construct with an eye on improving methodology and developing a more nuanced understanding of how relational dynamics influence the course and outcome of therapy.

References

Albani, C., Benninghoven, D., Blaser, G., (1999). On the connection between affective evaluation of recollected relationship experience and the severity of the psychic impairment. *Psychotherapy Research, 9*, 4, 452-467.

Andersen, S. M., & Berk, M. S. (1998). Transference in everyday experience: Implications of experimental research for relevant clinical phenomena. *Review of General Psychology, 2*, 1, 81-120.

Andersen, S. M., Baum, A. (1994). Transference in interpersonal relations: Inferences and affect based on significant-other representations. *Journal of Personality, 62*, 460-497.

Andersen, S. M., Cole, S. W. (1990). "Do I know you?": The role of significant others in general social perception. *Journal of Personality and Social Psychology, 59*, 384-399.

Andersen, S. M., Glassman, N. S., Chen, S., & Cole, S. W. (1995). Transference in social perception: The role of chronic accessibility in significant-other representations. *Journal of Personality and Social Psychology, 69*, 41-57.

Andersen, S. M., Reznik, I., & Manzella, L. M. (1996). Eliciting transient affect, motivation, and expectancies in transference: Significant-other representation and the self in social relations. *Journal of Personality and Social Psychology, 71*, 1108-1129.

Arnow, B. A. (2005). Cognitive behavioral analysis system of psychotherapy for chronic depression. *Cognitive and Behavioral Practice, 12*, 1, 6-16.

Barber, J. P., Foltz, C., DeRubeis, R. J., & Landis, J. R. (2002). Consistency of

interpersonal themes in narratives about relationships. *Psychotherapy Research, 12*, 139-158.

Barber, J. P., Crits-Christoph, P., & Luborsky, L. (1998). A guide to the CCRT standard categories and their classification. In: *Understanding transference: The Core Conflictual Relationship Theme method* (2nd ed.). Luborsky, Lester; Crits-Christoph, Paul; Washington, DC: American Psychological Association, 1998. 43-54.

Battle, C. C., Imber, S. D., Hoehn-Saric, R., Strone, A. R., Nash, E. H., & Frank, J. D. (1966). Target complaints as criteria for improvement. *American Journal of Psychotherapy, 20*, 184-192.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Beitman, B. D. (2005). To the editor: Defining core processes of psychotherapy. *American Journal of Psychiatry, 162*, 8, 1549-1550.

Benjamin, J. (1995). Sameness and difference: Towards an "overinclusive" model of gender development. *Psychoanalytic Inquiry, 15*, 125-142.

Berk, M. S., Andersen, S. M. (2000). The impact of past relationships on interpersonal behavior: Behavioral confirmation in the social-cognitive process of transference. *Journal of Personality and Social Psychology, 79*, 4, 546-562.

Chance, S. E., Bakemann, R., Kaslow, N. J., Farber, E., & Burge-Callaway, K. (2000). Core conflictual relationship themes in patients diagnosed with borderline personality disorder who attempted, or who did not attempt, suicide. *Psychotherapy Research, 10*, 337-355.

Chandler, L. A., & Gallagher, R. P. (1996). Developing a taxonomy for problems seen at a university counseling center. *Measurement and Evaluation in Counseling and Development, 29*, 4-12.

Cierpka , M., Strack, M., Benninghoven, D., Staats, H., Dahlbender, R., Pokorny, D., Frevert, G., Blaser, G., Kachele, H., Geyer, M., Komer, A., & Albani, C. (1998). Stereotypical relationship patterns and psychopathology. *Psychotherapy and Psychosomatics, 67*, 241-248.

Connolly, M. B., Cris-Christoph, P., Barber, J. P., Luborsky, L. (2000). Transference patterns in the therapeutic relationship in supportive-expressive psychotherapy for depression. *Psychotherapy Research, 10*, 356-372.

Connolly, M. B., Crits-Christoph, P., Demorest, A., Azarian, K., Muenz, L., Chittams, J. (1996). Varieties of transference patterns in psychotherapy. *Journal of Consulting* and Clinical Psychology, 64, 1213-1221.

Crits-Christoph, P., Cooper, A., Luborsky, L. (1988). The accuracy of therapists interpretations and the outcome of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 56*, 4, 490-495.

Diguer, L., Lefebvre, R., Drapeau, M., Luborsky, L., Rousseau, J.-P., Hebert, E., Daoust, J.-P., Pelletier, S., Scullion, M., Descoteaux, J. (2001). The core conflictual relationship theme of psychotic, borderline, and neurotic personality organizations. *Psychotherapy Research, 11*, 169-186.

Drapeau, M., & Perry, J. C. (2004). Childhood trauma and adult interpersonal functioning: a study using the Core Conflictual Relationship Theme Method (CCRT). *Child Abuse and Neglect, 28*, 1049-1066.

Drapeau, M., DeRoten, Y., & Korner, A. C. (2004). An exploratory study of child molester's relationship patterns using the Core Conflictual Relationship Theme Method. *Journal of Interpersonal Violence, 19*, 2, 264-275.

Dunkle, J. H., & Friedlander, M. L. (1996). Contribution of therapist experience and personal characteristics to the working alliance. *Journal of Counseling Psychology, 43*, 456-460.

Ekstrom, S. R. (2002). A cacophony of theories: Contributions towards a story-based understanding of analytic treatments. *Journal of Analytical Psychology, 47*, 339-358.

Festinger, L. (1957). *A theory of cognitive dissonance.* Evanston, IL: Row, Peterson and Company

Field, A. (2005). *Discovering statistics using SPSS*, (2nd edition). Thousand Oaks, CA: Sage Publications.

Freeman, A. , Pretzer, J., Fleming, B., & Simon, K. M. (1990) *Clinical applications of cognitive therapy*, New York: Plenum Press

Fried, D., Crits-Christoph, P., Luborsky, L. (1992). The first empirical demonstration of transference in psychotherapy. *Journal of Nervous and Mental Disease, 180*, 5, 326-331.

Freud, A. (1990). Transference. In A. H. Esman (Ed.), *Essential papers on transference*. New York: New York University Press. (original work published in 1936).

Freud, S. (1909). *Five lectures on psychoanalysis*, Standard Edition 11, London : Hogarth Press.

Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship*. New York: Wiley

Gelso, C. J., Hill, C. E., Mohr, J. J., Rochlen, A. B., Zack, J. (1999). Describing the face of transference: Psychodynamic therapists' recollections about transference in cases of successful long-term therapy. *Journal of Counseling Psychology, 46*, 257-267.

Greenberg, L. S., Rice, L. N., &Elliot, R. (1993). *Facilitating emotional change: The moment by moment process*. New York: Guilford Press.

Grenyer, B. F. & Luborsky, L. (1996). Dynamic change in psychotherapy: Mastery of interpersonal conflicts. *Journal of Consulting and Clinical Psychology, 64*, 2, 411-416

Guadagnoli, E., & Velicer, W. F. (1988). Relation of sample size to the stability of component patterns. *Psychological Bulletin, 103*, 2, 265-275.

Heppner, P. P., Kivlighan, D. M., & Wampold, B. E. (1999). *Research design in counselling*, (2nd ed.). Belmont, CA: Wadsworth Publishing Company.

Hinkley, K., & Andersen, S. M. (1996). The working self-concept in transference: Significant-other activation and self-change. *Journal of Personality and Social Psychology, 71*, 1279-1295.

Hollon, S. D., & Kriss, M. R. (1984). Cognitive factors in clinical research and practice. *Clinical Psychology Review, 4*, 1, 35-76.

Horowitz, M. J. (1989). Relationship schema formulation: Role relationship models and intrapsychic conflict. *Psychiatry, 52*, 260-274.

Horowitz, M. J. (1994). Configurational analysis and the use of relationship models to understand transference. *Psychotherapy Research, 4*, 184-196.

Horvath, A. O., & Symonds, D. (1991). Relationship between working alliance and

outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139-149.

Hunsley, J., Lee, C. M., & Aubry, T. (1999). Who uses psychological services in Canada?, *Canadian Psychology, 40*, 3, 1-13.

Juni, S. (1995). Triangulation as splitting in the service of ambivalence. *Current Psychology, 14*, 2, 91-112.

Kaiser, H. F. (1960). The application of electronic computers to factor analysis. *Educational and Psychological Measurement, 20*, 141-151.

Kelly, G. A. (1955). *The psychology of personal constructs* (Vol. 1). New York: Norton.

Kivlighan, D., Patton, M. J., & Foote, D. (1998). Moderating effects of client attachment on the counselor experience-working alliance relationship. *Journal of Counseling Psychology, 45*, 3, 274-278.

Klein, M. (1975). Notes on some schizoid mechanisms. In *Envy and gratitude and other works,* 1946-1963 (pp.24-42). New York: Delacorte. (Original work published in 1946)

Leising, D., Rudolf, G., Stadler, K., Jakobsen, T., Oberbracht, C., & Grande, T. (2003). Do interpersonal behavior and emotional experience change in the course of successful long-term psychoanalytic therapies? *Psychotherapy Research, 13*, 461-474.

Levine, F. J., & Luborsky, L. (1981). The Core Conflictual Relationship Theme Method: A demonstration of reliable clinical inferences by the method of mismatched cases. In S. Tuttmen, C. Kaye, and M. Zimmerman (Eds.), *Object and self: A developmental approach.* New York: International Universities Press.

Luborsky, L. (1977). Measuring a pervasive psychic structure in psychotherapy: The Core Conflictual Relationship Theme. In N. Freedman & S. Grand (Eds.), *Communicative structures and psychic structures* (pp. 367-395), New York: Plenum Press

Luborsky, L. (1998). Why each CCRt procedure was chosen. In L. Luborsky and P. Crits-Christoph (Eds.) *Understanding Transference: The Core Conflictual Relationship Theme method.* (2nd ed.). (pp. 121-132). Washington DC: American Psychological Association

Luborsky, L., & Crits-Christoph, P. (1988). Measures of psychoanalytic concepts: The last decade of research from "the Penn studies". *International Journal of Psycho-Analysis, 69*, 1, 75-86.

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding Transference: The Core Conflictual Relationship Theme method.* New York: Basic Books.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding Transference: The Core Conflictual Relationship Theme method.* (2nd ed.). Washington DC: American Psychological Association

Luborsky, L., Crits-Christoph, P., & Mellon, J. (1986). Advent of objective measures of the transference concept. Special Issue: Psychotherapy Research. *Journal of Consulting and Clinical Psychology, 54*, 39-47.

Luborsky, L. & Diguer, L. (1998). The reliability of the CCRT measure: Results from eight samples. In L. Luborskky and P. Crits-Christoph (Eds.), *Understanding Transference: The Core Conflictual Relationship Theme Method* (2nd ed.). Washington DC: American Psychological Association.

Luborsky, L., Diguer, L., Andrusyna, T., Friedman, S., Tarca, C., Popp, C. A., Ermold, J., & Silberschatz, G. (2004). A method of choosing CCRT scorers. *Psychotherapy Research, 14*, 127-134.

Luborsky, L., Mellon, J., van Ravenswaay, P., Childress, A. R., Cohen, K. D., Hole, A. V., Ming, S., Crits-Christoph, P., Levine, F. J., & Alexander, K. (1985). A verification of Freud's grandest clinical hypothesis: The transference. *Clinical Psychology Review, 5*, 231-246.

Luborsky, L., Popp, C., & Barber, J. P. (1994). Common and special factors in different transference-related measures. *Psychotherapy Research, 4*, 277-286.

MacCallum, R. C., Widaman, K. F., Zhang, S., & Hong, S. (1999). Sample size in factor analysis. *Psychological Methods, 4*, 84-99.

MacCallum, R. C., Widaman, K. F., Preacher, K. J., & Hong, S. (2001). Sample size in factor analysis: The role of model error. *Multivariate Behavioral Research, 36*, 611-637.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

Meissner, W. W. (2001). A note on transference and alliance: II. Patterns of interaction. *Bulletin of the Menninger Clinic, 65*, 2, 219-245.

Mermelstein, J. J (2000). The role of concordance and complementarity in psychoanalytic treatment. *Psychoanalytic Psychology, 17*, 4, 706-729.

Paivio, S. C., & Bahr, L. M. (1998). Interpersonal problems, working alliance, and outcome in short-term experiential therapy. *Psychotherapy Research, 8*, 392-407.

Racker, H. (1968). *Transference and countertransference*. New York: Internaltional Universities Press.

Safran, J. D., & Segal, S. V. (1990). *Interpersonal process in cognitive therapy*. New York: Basic Books.

Schacht, T. & Binder, J. (1982). Focusing: A manual for identifying a circumscribed area of work for time-limited dynamic psychotherapy (TLDP). Unpublished Manuscript, Vanderbilt University.

Schacht, T. E., & Henry, W. P. (1994). Modeling recurrent patterns of interpersonal relationship with structural equation analysis of social behavior. The SASB-CMP. *Psychotherapy Research, 4*, 208-221.

Schneider, J. A. (2003). Working with pathological and healthy forms of splitting: A case study. *Bulletin of the Menninger Clinic, 67*, 1, 32-49.

Sexton, H. C., Hembre, K., & Kvarme, G. (1996). The interaction of the alliance and therapy microprocesses: A sequential analysis. *Journal of Consulting and Clinical Psychology, Vol 64*, 3, 471-480.

Shrout, P. E., & Fleiss, J. L. (1979). Intraclas correlations: Uses in assessing rater reliability. *Psychological Bulletin, 86*, 420-428.

Soldz, S. (1993). Beyond interpretation: The elaboration of transference in personal construct therapy. In L. Leitner & N. Dunnett (Eds.), *Critical issues in personal construct psychotherapy* (pp. 173-192). Malabar, FL: Robert E. Krieger

Stevens, J. (1996). *Applied multivariate statistics for the applied social sciences*, (3rd ed.). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Vanheule, S, Desmet, M., Rosseel, Y., & Meganck, R. (2006). Core transference themes in depression. *Journal of Affective Disorders, 91*, 1, 71-75.

Waldinger, R. J., Toth, S. L., & Gerber, A. (2001). Maltreatment and internal representations of relationships: Core relationship themes in the narratives of abused and neglected preschoolers. *Social Development, 10*, 41-48.

Westen, D. (1991). Social cognition and object relations. *Psychological Bulletin, 109*, 429-455.

Wilczec, A., Weinryb, R. M., Barber, J. P., Gustavsson, J. P., & Asberg, M. (2004). Change in the core conflictual relationship theme after long-term dynamic psychotherapy. *Psychotherapy Research, 14*, 1, 107-125.

Wilczec, A., Weinryb, R. M., Barber, J. P., Gustavsson, J. P., & Asberg, M. (2000). The core conflictual relationship theme (CCRT) and psychopathology in patients selected for dynamic psychotherapy. *Psychotherapy Research, 10*, 100-113.

Table 1

Means, Standard Deviations and Ranges for Each W, RO and RS Cluster (N = 22)

Clusters	M (SD)	Range
Wishes		
OWC1: To assert self and be independent with others	0.87 (0.72)	2.04
OWC2: To oppose, hurt and control others	0.61 (0.71)	1.78
OWC3: To be controlled, hurt, and not responsible with others	0.25 (0.49)	1.60
OWC5: To be close and accepting with others	1.42 (0.72)	2.46
OWC6: To be loved and understood by others	1.44 (0.66)	2.32
OWC7: To feel good and comfortable with others	0.86 (2.04)	2.04
OWC8: To achieve and help others	1.45 (0.33)	1.00
TWC5: To be close and accepting with the therapist	0.42 (0.52)	1.30
TWC6: To be loved and understood by the therapist	0.40 (0.56)	1.30
TWC8: To achieve and help the therapist	0.42 (0.58)	1.60
Responses of Other		
OROC1: Others are strong	1.18 (0.56)	1.85
OROC2: Others are controlling	1.14 (0.63)	2.04
OROC3: Others are upset	1.64 (0.62)	2.34
OROC4: Others are bad	1.18 (0.56)	1.95
OROC5: Others are rejecting and opposing	2.10 (0.38)	1.56
OROC7: Others like me	1.57 (0.60)	2.23

TROC1: Therapist is strong	0.20 (0.45)	1.48
TROC5: Therapist is rejecting and opposing	0.35 (0.52)	1.30
TROC6: Therapist is helpful	1.10 (0.69)	2.11
TROC7: Therapist likes me	1.20 (0.56)	2.00
TROC8: Therapist is understanding	1.16 (0.64)	2.04
Responses of Self		
ORSC2: Unreceptive with others	1.66 (0.73)	2.36
ORSC3: Respected and accepted with others	1.74 (0.37)	1.28
ORSC4: Oppose and hurt others	1.66 (0.66)	2.36
ORSC6: Helpless with others	1.63 (0.38)	1.34
ORSC8: Anxious and ashamed with others	1.48 (0.48)	2.11
TRSC1: Helpful with therapist	1.32 (0.52)	1.95
TRSC2: Unreceptive with therapist	0.60 (0.66)	1.78
TRSC3: Respected and accepted with therapist	1.18 (0.66)	2.00
TRSC4: Oppose and hurt therapist	0.41 (0.60)	1.48
TRSC5: Self-controlled and self-confident with therapist	0.52 (0.60)	1.60
TRSC6: Helpless with therapist	0.75 (0.64)	2.04
TRSC7: Disappointed and depressed with therapist	0.41 (0.50)	1.00
TRSC8: Anxious and ashamed with therapist	0.59 (0.58)	1.60

Note. OWC = other Wish cluster; TWC = therapist Wish cluster; OROC = other Response of Other cluster; TROC = therapist Response of Other cluster; ORSC = other Response of Self cluster; TRSC = therapist Response of Self cluster

Table 2

Summary of Items and Factor Loadings for Varimax Orthogonal Four-Factor Solution for Therapist and Other Wish Clusters (N = 22)

Cluster	Factor Loading 1	2	3	4	Communality
Wish to Be Loved and Understood By The Therapist, Not Others					
TWC8: To achieve and help the therapist	**.82**	.01	.16	-.03	.71
TWC6: To be loved and understood by the therapist	**.75**	.06	-.09	-.25	.63
OWC6: To be loved and understood by others	**-.69**	.37	.36	-.25	.81
Wish To Be Submissive With Others					
OWC3: To be controlled, hurt, and not responsible with others	-.05	**.82**	-.30	-.15	.79
OWC7: To feel good and comfortable with others	.00	**.65**	.17	.17	.49
OWC5: To be close and accepting with others	-.13	**.56**	.42	.24	.56
Wish to Dominate Others					
OWC2: To oppose, hurt and control others	-.08	-.05	**.91**	.01	.84
OWC1: To assert self and be independent with others	.17	.49	**.57**	.26	.67

Wish To Focus Help On Others					
OWC8: To achieve and help others	.09	.10	.25	**.81**	.74
TWC5: To be close and accepting with the therapist	.37	-.09	.13	**-.72**	.69

Note. Boldface indicates highest factor loadings. OWC = other Wish cluster; TWC = therapist Wish cluster.

Table 3

Summary of Items and Factor Loadings for Varimax Orthogonal Four-Factor Solution for Therapist and Other RO Clusters (N = 22)

Cluster	Factor Loading 1	2	3	4	Communality
Others Are Rejecting And Opposing, Therapist Is Not					
OROC5: Others are rejecting and opposing	**.82**	-.06	.02	.15	.70
OROC2: Others are controlling	**.79**	-.10	.29	.19	.75
TROC5: Therapist is rejecting and opposing	**-.67**	.35	-.11	-.02	.58
OROC1: Others are strong	**.58**	-.34	.35	-.23	.63
Positive Response From Therapist					
TROC6: Therapist is helpful	-.30	**.79**	-.10	-.10	.73
TROC7: Therapist likes me	.13	**.78**	-.19	.38	.80
TROC8: Therapist is understanding	-.33	**.67**	.06	-.22	.61
Ambivalent Response From Others					
OROC4: Others are bad	.18	.10	**.86**	-.01	.78
OROC7: Others like me	.07	-.33	**.77**	.10	.71

Others Are Upset, Therapist Is Strong					
OROC3: Others are upset	.30	-.04	-.01	**.82**	.76
TROC1: Therapist is strong	-.57	.01	.23	**.65**	.80

Note. Boldface indicates highest factor loadings. OROC = other Response of Other cluster; TROC = therapist Response of Other cluster.

Table 4

Summary of Items and Factor Loadings for Varimax Orthogonal Four-Factor Solution for Therapist and Other RS Clusters (N = 22)

Cluster	Factor Loading 1	2	3	4	Communality
Negative/Passive Response To Others					
ORSC8: Anxious and ashamed with others	**.89**	.17	-.08	-.10	.83
ORSC2: Unreceptive with others	**.78**	-.44	.10	.09	.83
ORSC6: Helpless with others	**.69**	-.41	-.16	-.22	.72
Control Issues With Therapist, Not With Others					
ORSC4: Oppose and hurt others	.31	**-.86**	.31	.16	.95
TRSC5: Self-controlled and self-confident with therapist	-.02	**.62**	.01	.37	.53
TRSC6: Helpless with therapist	.22	**.54**	.44	-.07	.54
TRSC4: Oppose and hurt therapist	-.27	**.51**	.31	-.13	.44

Ambivalent Response To Therapist					
TRSC1: Helpful with therapist	-.30	.09	**.78**	-.11	.72
TRSC2: Unreceptive with therapist	.20	.04	**.71**	.11	.56
TRSC3: Respected and accepted with therapist	-.13	-.03	**.63**	.17	.44
Feel Bad With Others, Feel Bad With Therapist					
ORSC3: Respected and accepted with others	.25	.20	.21	**-.78**	.76
TRSC8: Anxious and ashamed with therapist	-.08	.32	.19	**.71**	.65
TRSC7: Disappointed and depressed with therapist	.21	-.12	.44	**.68**	.71

Note. Boldface indicates highest factor loadings. ORSC = other Response of Self cluster; TRSC = therapist Response of Self cluster.

Relationship Between the First and Second Studies

The main objective of the second study was to address some of the limitations of current transference research by exploring an alternate source of therapist narratives for use with the CCRT method. In order to isolate the impact of the source of therapist narratives, this investigation used a participant sample and methodology similar to that used in the first study, varying only the method used to obtain data about the clients' relationship with the therapist.

In the first study, therapist narratives were drawn from within the first three psychotherapy sessions. Clients' descriptions of the therapeutic relationship were limited to what clients were willing to share with the therapist. In the second study, therapist narratives were culled from *Participant Critical Event* (PCE; Fitzpatrick & Chamodraka, submitted) interviews, collected after the third session of therapy. These interviews were designed to access significant events in the formation of the therapeutic relationship and were gathered from outside the psychotherapy sessions by interviewers. The effect of this was to allow clients to explore their relationships with their therapists with the same privacy afforded to their exploration of relationships with significant others in psychotherapy sessions.

The use of PCE interviews as a source of therapist narratives addresses the problem of limiting the sample to clients who are willing to explore the therapeutic relationship with their therapist. Additionally, the structure of the PCE interviews ensures access to therapist narratives that clients perceive as significant to the formation of the therapeutic relationship, thus providing high-quality narratives that capture the most salient moments of the client-therapist interaction in the first three sessions of therapy.

Running head: THE MANIFESTATION OF TRANSFERENCE

The Manifestation of Transference in the Formation of the Therapeutic Relationship: Exploring an Alternate Data Source for Therapist Narratives in Transference Research

Catherine Tellides, M.Ed., Marilyn Fitzpatrick, Ph.D., Martin Drapeau Ph.D., Robert Bracewell, Ph.D., Martha Chamodraka, M.A., Nadia Marini, M.A.

McGill University

The authors gratefully acknowledge the contribution of Jennifer Janzen, M.A. and Alexia Jaouich, M.A., for their assistance in data collection, and William B. Jaffee, Ph.D. for his assistance with the editing of this manuscript.

Correspondence concerning this article should be sent to Catherine Tellides, McLean Hospital, 115 Mill St., Belmont, MA 02478. ctellides@mclean.harvard.edu

Abstract

Previous transference studies have compared in-session client narratives about significant others to in-session client narratives about the therapist, limiting data to the information that clients are willing to share with the therapist. In this study, the first three sessions of 30 therapies (N = 30) with high-functioning individuals were examined using the *Core Conflictual Relationship Theme* method (CCRT). Client narratives about others were drawn from the psychotherapy sessions and client narratives about the therapist were drawn from a *Participant Critical Event* (PCE) interview conducted after the third session of therapy.

Factor analyses of the Wish (W) and Response of Other (RO) components of the CCRT indicate a complementary pattern of relating, in which the therapist is devalued and others are idealized. Findings for the Response of Self (RS) component indicate a concordant relational transfer, in which clients feel bad with both the therapist and others. Additionally, the factor structure of the W and RO components suggests that as clients experience control issues with significant others, they wish to adopt a submissive stance toward the therapist. Taken together with results from a study by Tellides and colleagues (2006) that used a similar sample but different source of therapist narratives, these results suggest that the source of therapist narratives may influence the results of transference research.

KEY WORDS: Therapeutic transference, relationship patterns, Core Conflictual Relationship Theme, CCRT

Transference, or the *transfer* of an individual's core relational schemas across relationships (Freud, 1909), is a key element of most psychodynamic and psychoanalytic therapies (Gelso, Hill, Mohr, Rochlen, & Zack, 1999). There is also strong evidence that transference plays an important role in non-analytic therapies (Gelso & Hayes, 1998). Clients' past relationships and current capacity to form a positive and productive relationship with the therapist interact in a way that is highly relevant to all treatment modalities (Beitman, 2005; Gaston et al., 1995; Luborsky et al., 1985; Paivio & Bahr, 1998). A research-based understanding of therapy and extra-therapy relationships and the interaction between these is needed to inform current clinical practice.

Across schools of therapy, researchers have explored aspects of transference using a variety of methodological approaches (e.g. brief psychodynamic: *Cyclic Maladaptive Patterns*: Strupp & Binder, 1984; cognitive: *Role-Relationship Models Configuration*: Horowitz et al., 1991; constructivist: *Role Construct Repertory*, Kelly, 1955; interpersonal: *Impact Message Inventory*, Kiesler & Schmidt, 1993 and *Structural Analysis of Social Behaviour*: SASB, Benjamin, 1974; narrative: *Personal Scripts*, Tompkins, 1979; and object relations: *Montreal Transference and Countertransference Measure*, Bouchard et al., 1997 and *Psychotherapy Relationship Questionnaire*, Westen, 2000). Although these instruments differ considerably in their operational constructs, they all face one common challenge: the collection of relationship data that will serve to guide researchers and clinicians in an accurate understanding of relational phenomena (Luborsky, 1998). Transference-related measures typically involve therapist, client or observer ratings on data drawn from psychotherapy sessions, interviews and questionnaires.The sources of relationship data and more specifically, factors that may

influence the report of relationship data are of critical relevance to the measurement of transference.

The *Core Conflictual Relationship Theme* (CCRT) method (Luborsky, 1977; Luborsky & Crits-Cristoph, 1990, 1998) uses observer ratings of client self-report data from psychotherapy sessions and interviews to measure the central patterns, scripts, or schemas that individuals follow in relationships. Client relationship narratives are scored for three components: The client's main wishes, needs, or intentions (W), the responses from the other person (RO), and the responses of the self (RS). The CCRT is one of the earliest and most popular methods of narrative analysis in psychotherapy research (Diguer et al., 2001). This method paved the way for several of the existing transference-related measures and consistently emerges as one of the most useful instruments in developing a body of clinically-relevant transference research.

CCRT-Based Transference Research

Although the CCRT was designed as an operationalization of transference (Luborsky, 1998), very few CCRT studies have focused on evaluating *therapeutic* transference, or the relation of clients' interpersonal themes outside of therapy to the relationship experienced with the therapist (Barber, Foltz, DeRubeis, & Landis, 2002; Connolly, Crits-Christoph, Barber, & Luborsky, 2000)

The first study that investigated the transference phenomenon in therapy (Fried, Crits-Christoph, & Luborsky, 1992) used the original CCRT method to compare clients' in-session narratives about the therapist with clients' in-session descriptions of general relationship patterns. The study demonstrated a modest parallel between the relationship themes drawn from narratives about significant others in patients' lives and themes drawn

from narratives about the therapist. The authors hypothesized that the moderate levels of the results might have been due to the low number of therapist relationship episodes used to determine the client's relational theme with the therapist.

Connolly and colleagues (1996, 2000) examined the relationship between the multiplicity of client themes about significant others and the theme about the therapist, using the *Quantitative Assessment of Interpersonal Themes* (QUAINT) method (Crits-Christoph, Demorest, & Connolly, 1990). In this method, different narratives told by a single patient are randomly combined with the narratives from other patients and rated independently using a set of standard categories. Every item in the set of standard categories for the Wish, Response of Others, and Response of Self components is rated on a scale of one to five according to the degree it applies to a given narrative. The authors of the 1996 study found that for approximately 60% of the patients there was a significant correlation between themes about significant others and about the therapist, and that for 34% of the patients the most pervasive theme for others correlated with the therapist theme. The authors of the 2000 study found a significant correlation between other and therapist themes for 50% of the patients, and a significant correlation between the most pervasive theme for others and the therapist theme for 33% of the patients.

In the QUAINT method, patient narratives are randomly re-ordered and re-combined so as to prevent raters from overstating the similarity of relationship narratives in a single psychotherapy session. Although this approach may reduce rater bias, it also obscures each patient's complete story and reduces raters' capacity to perceive the client's narratives in a manner similar to how they are understood by the therapist during the session, potentially limiting the generalizability of the findings to clinical practice.

Tellides and colleagues (2006) used the CCRT method to examine the manifestation of transference in therapies of high-functioning clients. Separate factor analyses for the Wish (W), Response of Other (RO), and Response of Self (RS) components were used to uncover the latent data structure in the correlations between significant other and therapist CCRT clusters. Findings within the W and RO components indicated a complementary transference pattern in which the therapist was idealized and others were devalued, and findings within the RS component indicated a concordant relational transfer, in which clients had a negative response to both the therapist and others. The absence of concordant relational patterns for therapists and significant others across all three CCRT components is different from CCRT transference studies that sampled pathological populations (Fried et al., 1992, Connolly et al., 1996, 2000) and indicate that there may be ways high-functioning clients interact with their therapist and significant others that are different from more severely distressed clients.

General Limitations of CCRT-Based Transference Research

Transference research is charged with exploring an elusive interpersonal phenomenon in a way that is both scientifically rigorous and clinically relevant. Although the CCRT has strong psychometric properties and compelling face validity (Barber et al., 2002; Crits-Christoph, et al., 1988; Levine & Luborsky, 1981; Luborsky et al., 1986; Luborsky & Crits-Christoph, 1998; Luborsky & Diguer, 1998), there are subtle yet significant methodological challenges facing researchers using the measure; in the study of transference, "the devil is in the details".

One limitation of transference research is that therapist and other-person narratives drawn from psychotherapy sessions are different in an important way. In-

session client narratives that yield relationship themes with significant others are relayed to the therapist, affording the patients' a private exploration of their interactions with those individuals. Conversely, in-session therapist narratives used as a source of relationship themes with the therapist are necessarily shared *with* the therapist, potentially limiting clients' willingness to expose those interactions-- "it is difficult to talk to the therapist about the therapist" (Fried et al., 1992, p.330).

Another limitation associated with extracting therapist narratives from within psychotherapy sessions is that the sample is limited to clients who directly address the therapeutic relationship in-session. In the transference studies reviewed, only patients who recounted or enacted at least one therapist relationship narrative in the course of their therapy were studied. This is a much-truncated sample of the actual patients who may have transference feelings or reactions to their therapists. The CCRT is most sensitive to "explicit enactments or verbalizations of the transference" and may fail to capture transference "for patients who do not explicitly discuss their relationship with the therapist during a session" (Connolly et al., 1996, p.1218). It is arguable that transference studies thus far have actually been explorations of transference for patients who are willing to explicitly address the therapeutic relationship with their therapist.

Therapist relationship episodes culled from psychotherapy sessions are not only scarce, but they do not necessarily offer clinically significant narratives about the therapeutic relationship. The episodes provided by clients within psychotherapy sessions are bound by the demand characteristic of talking to the therapist about the therapist and are not necessarily the most salient aspects of the therapeutic interaction. Although transference researchers have acknowledged the problem inherent in determining a

therapist relational theme from a single narrative, the actual limitation of the studies may have less to do with the *number* of therapist narratives utilized, than with the *quality* of therapist narratives available for study. It would be advantageous, then, to locate events that are critical to the therapeutic relationship to highlight interactions that characterize the development of the relationship. Although guided interviews are an established source of relationship episodes in the CCRT method (Luborsky & Crits-Christoph, 1998), to date, researchers have consistently drawn therapist relationship narratives from psychotherapy sessions. Out-of-session interviews represent an opportunity for improvements in the collection of narratives about the therapist in that they create a parallel opportunity for all participants to report relationship patterns with the therapist, and can identify significant-event-focused *high-quality* therapist narratives.

In conclusion, the study of therapeutic transference is an important avenue of research, with far-reaching implications for clinical practice, research and training across several theoretical orientations. The CCRT transference studies conducted thus far indicate both concordant and complementary interactions between relationship patterns experienced with significant others and those experienced with the therapist. Although each of these studies built on and improved certain aspects of the methodology used in the study of transference, a number of limitations remain. The purpose of the current study is to extend knowledge about therapeutic transference, while addressing some of the persistent limitations in existing research

The present investigation explores the relation between high-functioning clients' interpersonal themes in early therapy sessions and the interpersonal theme verbalized in narratives about the therapist during a guided interview conducted after the third session

of therapy. The first three sessions of psychotherapy were targeted because researchers have found them to be critical to the formation of one aspect of the therapeutic relationship, namely, the therapeutic alliance (Horvath & Symonds, 1991; Martin, Garske & Davis, 2000; Sexton, Hembre, & Kvarme, 1996). As the alliance is largely considered to be entwined with transference (Gelso & Carter, 1994; Meissner, 2001), it seems highly appropriate to explore the transference that manifests itself in early therapy sessions.

The source of therapist narratives was varied from that used in previous CCRT research in order to address the limitations associated with the use of therapist narratives from within psychotherapy sessions. However, the full impact of this methodological variation could only be determined if all other aspects of the study were consistent with another study that derived therapist narratives from sessions. This study was designed to build on the work of Tellides and colleagues (2006), using a similar participant sample and methodology, and diverging only in the use of interviews as a source of therapist narratives. The majority (i.e. 73%) of the client participants from the first study were included in the present investigation, and all instruments and methods of analysis were kept the same to ensure adequate comparability of the findings.

This study will explore the relationship between client themes about significant others and client themes about the therapist in early therapy, when the clients are high-functioning individuals, and therapist themes are drawn from out-of-session guided interviews.

Method

Participants

Clients. Thirty clients (24 women and 6 men), ranging in age from 20 to 55 years (M = 28.66, SD = 10.40) participated in this study. They identified themselves as Caucasian (n = 10), European (n = 8), Other (n = 5), Asian-Canadian (n = 3), Middle-Eastern (n = 2), Hispanic (n = 1), and Unknown (n = 1). The clients were students enrolled in a counselling course in a human sciences program at a Canadian university. Their participation in counselling was an optional experiential component of a course on counselling theory and practice.

Client presenting problems were identified using the *Target Complaints* (TC; Battle et al., 1966), which invites participants to specify three issues they would like to examine in therapy. Two advanced doctoral students then classified the clients' responses according to the *Taxonomy of Client Problems Seen in College and University Counselling Centers* (Chandler & Gallagher, 1996). Twenty-three of the 30 participants identified at least one target issue prior to the first therapy session. These were classified according to the taxonomy as follows: (a) Relationship difficulties 51%, (b) Self-Esteem 22%, (c) Academic concerns 7%, (d) Career concerns 5%, (e) Eating disorder 5%, (f) Existential concerns 3%, (g) Anxiety 3%, (h) Depression 2%, (i) Sexual abuse and harassment 2%. These responses indicate that clients were presenting with target complaints typically seen at university counselling centers.

Counsellors. Twenty-six counsellors (21 women and 5 men), ranging in age from 22 to 49 years (M = 31.07, SD = 6.18) participated in this study. They identified themselves as Caucasian (n = 18), European (n = 4), Other (n = 3), and Middle-Eastern

(n = 1). The counsellors were first-year Master's students in counselling psychology completing a practicum. Their training followed an integrative, common factors philosophy informed by psychodynamic, cognitive-behavioral, humanistic, and process-experiential traditions. One counsellor saw three clients, two counsellors saw two clients, and the rest saw one client each.

Instruments

The Core Conflictual Relationship Theme (CCRT) Method (Luborsky, 1977; Luborsky & Crits-Christoph, 1998). The CCRT was used to assess client relationship patterns. Details regarding the CCRT method can be found in Tellides and colleagues (2006). Briefly, the CCRT assesses relationship patterns by examining the wishes, needs, and intentions of the client (W); the response of others to the client (RO); and the response of the client to others (RS) found in relationship narratives shared by the client during psychotherapy sessions or an interview (Luborsky, 1998). CCRTs were scored with standard categories and clustered into 8 W, 8 RO, and 8 RS clusters (Crits-Christoph & Demorest, 1988, as cited in Luborsky & Crits-Christoph, 1998).

There is good evidence for the reliability and validity of the CCRT (Barber et al., 2002; Crits-Christoph, Luborsky, Dahl, & Popp, 1988; Levine & Luborsky, 1981; Luborsky & Crits-Christoph, 1998; Luborsky, Crits-Christoph, & Mellon, 1986; Luborsky & Diguer, 1998). The CCRT also has strong convergent validity with other transference-related measures, but has a more reliable scoring method and is considerably more time-efficient than similar measures (Luborsky, Popp, & Barber, 1994).

Procedures

The data were drawn from the first three sessions of thirty psychotherapies, twenty-two of which overlap with those included in Tellides and colleagues (2006). Psychotherapy sessions were transcribed, segmented into relationship narratives and rated according to the CCRT method (Luborsky, 1977; Luborsky & Crits-Christoph, 1990, 1998) until a total of ten significant-other relationship episodes were identified for each case (as suggested by Luborsky, 1998). The significant-other relationship episodes culled from the psychotherapy sessions were used to determine clients' relationship patterns with significant others.

In addition to the sessions, the data also included a *Participant Critical Events* (PCE; Fitzpatrick & Chamodraka, submitted) interview with each client at the end of the third session. Therapist relationship episodes drawn from the PCE interview were used to determine client relationship patterns with the therapist. Eight of the participants who shared at least one therapist relationship episode in the interview did not share any during the first three sessions of therapy, making them viable candidates for this study, but not for Tellides and colleagues (2006). Thus, these eight participants represent the difference in the sample between the two studies.

The PCE interviews followed a semi-structured protocol designed to access and identify events of significance to therapy participants in the development of their relationships with their therapists (see Appendix B). Clients were interviewed after the third session of counselling to ensure that the early therapeutic relationship was targeted. In the PCE interviews, the clients were asked to describe their expectations of the therapeutic relationship, describe how the relationship got started, and offer the "best

example" of how the relationship got started- in other words, a critical incident or interaction in the formation of the therapeutic relationship. They were then asked for their own contributions (behavioral and attitudinal) to the incident as well as those of the counsellor. PCE interviewers were advanced doctoral students trained by the researcher who developed the interview protocol. All interviews were audiotaped, transcribed, segmented into therapist relationship episodes, and rated according to the CCRT method (Luborsky, 1977; Luborsky & Crits-Christoph, 1990, 1998). The relationship episodes were scored as if they were elicited by a RAP interview (E.g. Waldinger et al., 2002) or found in a psychotherapy session.

Training process for CCRT rating. Details regarding the training process for CCRT rating can be found in Tellides and colleagues (2006). Interrater reliability on CCRT clusters was assessed using intraclass correlation coefficients (ICC) (Shrout and Fleiss, 1979). When raters achieved adequate reliability (i.e. ICC (2,1) W = 0.98, RO = 0.95, and RS = 0.87; Drapeau & Perry, 2004, Drapeau, DeRoten, & Korner, 2004, Luborsky & Diguer, 1998, Luborsky et al., 2004) for ratings on sample psychotherapy sessions, they proceeded to rate psychotherapy session transcripts and interviews designated for use in this study. Throughout the rating process, reliability checks consisted of comparing the ratings of two raters on twenty percent of the transcripts. Reliability checks never fell below acceptable levels (i.e. two consecutive ICCs below 0.70).

Data Analysis

To obtain findings comparable to those of Tellides and colleagues (2006), similar methods of data analysis were used. Intraclass correlation coefficients (ICC) (Shrout & Fleiss, 1979) were used to determine interrater reliability on the CCRT clusters. To investigate the relationship between client relational themes about others and client relational themes about the therapist, exploratory factor analyses, using principle components analysis (PCA) were used to examine the structure of correlations among frequencies of W, RO, and RSs clusters found in therapist and other-person narratives. Analysis was conducted at the level of clusters because the number of participants precluded an adequately powerful analysis of individual categories (Drapeau & Perry, 2004; Drapeau et al., 2004; Waldinger, Toth, & Gerber, 2001). Varimax rotation maximized the variance accounted for by each factor, to facilitate interpretation of the factors (Field, 2005). The number of factors extracted for each component was based on inspection of the scree plot (Field, 2005) and on eigenvalues greater than one (Kaiser, 1960).

Stevens (1996) generally recommends interpreting factor loadings with an absolute value greater than 0.40, but cautions against interpreting factors without consideration of sample size. Upon examining the data, and in consideration of the sample size in this study, factors were composed of items with loadings greater than or equal to an absolute value of 0.48. A more rigorous factor loading cut-off of 0.55 did not substantially alter the factor interpretation, indicating that items with loadings greater than 0.48 were of adequate substantive importance to each factor relative to sample size (Stevens, 1996). Additionally, MacCallum, Widaman, Zhang, and Hong (1999) and

MacCallum, Widaman, Preacher, and Hong (2001) suggest that if communalities (i.e. the amount of variance a variable shares with all the other variables included in the analysis) are high (0.60 or higher), recovery of population factors in the sample data is normally very good, regardless of sample size. As mean communality values for the W, RO and RS components in this study were all at or above 0.60, the factors derived from this sample promise to be representative of factors in the sampled population.

Log transformations were performed on the data to reduce the impact of the outliers that skewed the distribution (Field, 2005). Clusters in which the data did not attain a normal distribution following the transformations (kurtosis>3.0 or <-3.0) were eliminated from the analysis (Field, 2005). All clusters endorsed by fewer than 30% of the subjects (W other-person $N = 1$, W therapist $N = 2$, RO other-person $N = 2$, RO therapist $N = 2$, RS other-person $N = 5$, RS therapist $N = 1$) were dropped from the analysis rather than folded into other clusters (as in Waldinger and Colleagues, 2001) in order to maintain the integrity of the statistically-derived clusters (Barber, Crits-Christoph, & Luborsky, 1998).

Pearson correlations between the transformed variables were compared to the results of the Principal Components Analysis (PCA), to determine the consistency of the data structure. A visual examination indicated substantial similarities between the data structure found in the correlations and the structure uncovered by the PCA, suggesting an acceptable reliability in the findings. The results of PCA analyses of the transformed W, RO and RS clusters were compared to results of PCA analyses of untransformed clusters to determine whether the log transformations had vastly altered the latent data structure of the correlations. Visual examination showed a similar data structure, indicating that the

transformations did not substantially influence the latent factors uncovered in the factor analyses.

Results

Reliability

The median ICC (2, 1) was 0.94 for the wishes, 0.95 for the responses of other, and 0.87 for the responses of self, indicating acceptable reliability. The range of the ICCs was 0.77- 1.00 for the wishes, 0.76- 1.00 for the responses of other, and 0.49- 0.98 for the responses of self.

Descriptives

The means and standard deviations and range of the variables included in the analyses for the W, RO and RS components are included in Table 1. The mean number of therapist relationship episodes included in the analyses was 4.77 (median = 4.5), and the mean number of significant-other relationship episodes included in the analyses was 15.17 (median = 13).

Therapist and Other Wish Clusters

Following log transformations, the Wish clusters retained for analysis in the current study were: Other-person clusters 1, 2, 4, 5, 6, 7, 8 and therapist clusters 3, 4, 5, 6, 7, 8 (see Appendix A for cluster names). Four wish factors were extracted, accounting for 59.93% of the total variance of the thirteen wish clusters included in the analysis. Varimax-rotated factor loadings are shown in Table 2. Five items loaded heavily on Factor 1 (16.64% of the variance), named *Ambivalent Wishes With Others*, marked by items indicating a desire for both closeness and distance from others. Three items had high loadings on Factor 2 (15.82% of the variance), named *Positive Wishes With Therapist*. This factor was characterized by items suggesting a desire to help the therapist

and be close to and understood by the therapist. The third factor, *Wish To Feel Good and Comfortable with Others, Not With Therapist* (15.59% of the variance) had high loadings on three items and was marked by items indicating a desire to help others and feel good and comfortable with others and the absence of the desire to feel good and comfortable with the therapist. The fourth factor *Wish to be Submissive With Therapist,* marked by a desire to avoid conflict and surrender control to the therapist, (11.89%) had high loadings on two items.

Therapist and Other RO Clusters

Following log transformations, the following Response of Other clusters were retained for analysis: Other-person clusters 1, 2, 4, 5, 6, 7 and therapist clusters 1, 2, 3, 5, 6, 7 (see Appendix A for cluster names). Four RO factors were extracted, accounting for 66.08% of the total variance of the eleven RO clusters included in the analysis. Varimax-rotated factor loadings are shown in Table 3. Four items loaded heavily on Factor 1, named *Ambivalent Responses From Therapist* (19.45% of the variance). This factor included items suggesting the therapist was helpful, strong and agreeable as well rejecting and opposing. Two items loaded heavily on Factor 2, titled *Negative Responses from Others* (18.86% of the variance), which was marked by items indicating others were controlling, rejecting, and opposing. Factor 3, *Positive Responses from Others* (14.78% of the variance) loaded heavily on two items that indicated others were strong and agreeable, and factor 4 *Negative Responses from Therapist, Not From Others* (12.99% of the variance) loaded heavily on three items that indicated the therapist was upset and controlling but others were not bad.

Therapist and Other RS Clusters

Following log transformations, the RS clusters retained for analysis were: Other-person clusters 2, 4, 6 and therapist clusters 1, 2, 3, 5, 6, 7, 8 (see Appendix A for cluster names).Two RS factors were extracted, accounting for 59.27% of the total variance of the ten RS clusters included in the analysis. Varimax-rotated factor loadings are shown in Table 4. Six items loaded heavily on Factor 1, named *Ambivalent Responses to Therapist* (33.90% of the variance). This factor included items illustrating a variety of both positive and negative responses to the therapist. Four items loaded heavily on Factor 2, named *Feel Bad With Others, Feel Bad With Therapist* (25.37% of the variance), marked by items indicating distancing responses to others and the absence of perceived self-control and self-confidence with the therapist.

Discussion

The goal of this study was to use therapist relationship narratives drawn from out-of-session interviews to examine the transfer of relationship patterns between significant others and the therapist in the early therapies of high functioning clients. Findings within the W and RO components indicate a complementary pattern of relating, in which the therapist is devalued and others are idealized. However, findings within the RS component indicate a concordant relational transfer, in which clients feel bad with both the therapist and others. Additionally, some factors in the W and RO components suggest that clients experience control issues with significant others, but wish to adopt a submissive stance toward the therapist. In the following section, these results will be discussed in context of existing theoretical notions of transference and will be compared to previous CCRT-based transference studies, with a particular focus on Tellides and

colleagues' (2006) study which used a similar sample but a different source of therapist narratives.

Situation of Findings Within Theoretical Notions of Transference

Control mastery theory (CMT; Weiss & Sampson, 1986) suggests a type of therapeutic transference in which clients expose the therapist to behaviours they believe have historically invited harmful and threatening responses from significant others (Foreman, 1996). This type of transference is fundamentally a *test*, designed to determine whether the therapist will respond to the client with the same hostility received from significant others. Transference testing is considered an adaptive interpersonal strategy that enables clients to establish conditions of safety in treatment and invite a corrective emotional experience with the therapist (Weiss, 1994).

In this study, findings indicate that clients struggle with issues of closeness and autonomy in their relationships with significant others; The Ambivalent Wishes With Others factor includes wishes to be close, loved and understood by significant others and wishes to oppose, hurt, control, be independent, be distant, and avoid conflict with others. Luborsky, Barber, Shaffler, and Cacciola (1998) found that the two most frequent types of wishes uncovered by the CCRT are *To Be Close* and *To Be Independent*, and theorize that they are associated to each other in that they conflict, even in a nonpsychiatric population. Bowlby (1979) posits that conflicts between closeness and autonomy illustrate how healthy individuals use coping strategies and defense mechanisms to negotiate closeness with significant others. Although clients wish to be close to others, they also seek autonomy to defend against perceived threat (Negative Response From Others, including controlling, rejecting and opposing). According to CMT, the affective

discomfort associated with such a conflict can motivate clients to actively engage in treatment and test the expected threat with the therapist (Weiss, 1994).

In this study, the findings indicate that clients wish to be close with the therapist (Positive Wishes With Therapist, including wish to be close, accepting, loved, understood, and to achieve and help) and wish to behave submissively with the therapist (Wish To Be Submissive With Therapist). As a transference test, this suggests that clients may wish to determine whether the therapist will be able to respect their wishes for both closeness and autonomy in ways that significant others have not. Thus, clients may wish to give therapists *free reign* so as to test whether the therapist will abandon the relationship, dominate the relationship, or continue to respectfully engage in the relationship in a manner that attends to their needs for both closeness and autonomy.

It is important to note, however, that the desire to be submissive is found only in the W component and not the RS component, indicating that although clients may wish to behave submissively with the therapist, they have not yet elected to actively participate in the transference test at this early stage of treatment. Clients' ambivalence regarding issues of control and safety with the therapist (Ambivalent Responses From Therapist, including rejecting, opposing, strong and helpful and likes me, Negative response From Therapist, Not Others, including therapist is upset and controlling, others are not bad, Ambivalent Response To Therapist) may preclude active transference testing at this time.

Traditionally, therapeutic transference has been conceptualized within a paradigm of concordance- that is, as a direct transfer of client relationship patterns between significant others and the therapist (Freud, 1909; Freud, 1936/1990). However, some theorists posit that transference can occur in both a concordant *and* complementary

manner, wherein individuals use principles of sameness and difference to organize their relationships (Mermelstein, 2000). Findings from this study indicate that early in treatment, clients idealize significant others while devaluing the therapist (Wish To Feel Good And Comfortable With Others, Not Therapist, Negative Response From Therapist, Not Others). This suggests that as clients assimilate new relational experiences with the therapist in early treatment, they have expectations and perceptions of the therapist that are complementary to or opposite those they have of significant others. In therapies of relatively healthy individuals, this dichotomous organization of objects can be understood as a preparatory process toward the integration of the new experience with the therapist with existing experiences of significant others, and highlights the clients' desire to create order and safety in both relational spheres (Benjamin, 1995).

Findings also demonstrated a concordant relational transfer in the clients' response to the therapist and significant others (Feel Bad With Others, Feel Bad With Therapist). Although this finding partially confirms the traditionally- espoused notion of transference as a direct overlap in relational patterns, it captures more than mere concordance between therapist and other. Close examination of the clusters included in this factor reveals that when clients express being unreceptive, helpless, opposing and hurtful with others, they do not feel self-controlled or self-confident with the therapist. Understood in the context of clients' idealization of others and devaluation of the therapist, this factor may illustrate the cognitive dissonance clients experience when describing their negative responses to idealized significant others to a devalued therapist. It appears that in early treatment, as clients attempt to organize their experience of the

therapeutic relationship in the context of their existing relationships, they may ultimately feel bad with both objects.

Comparison of Findings to Previous CCRT-Based Transference Research

The findings from this study are remarkably different from those of previous studies in which concordant relational patterns were found between client narratives about significant others and client narratives about the therapist (Fried et al., 1992; Connolly et al., 1996, 2000). The difference in findings may be due to differences in client populations used in the studies. Studies that found a concordant transfer of relational patterns between significant others and the therapist (Fried et al., 1992; Connolly et al., 1996, 2000) examined the therapies of pathological clients, who have been found to have more rigid interpersonal patterns across relationships (Cierpka et al., 1998; Wilczek, Weinryb, Barber, Gustavsson, & Asberg, 2000). The present study used a sample of high-functioning college students who may be more likely to demonstrate a flexible interpersonal style. Tellides and colleagues (2006), who used a similar high-functioning sample, also found evidence of a complementary transference pattern between significant others and the therapist in the W and RO components and a concordant transference pattern in the RS component.

One objective of the present study was to examine transference using a source of therapist narratives different from that which is commonly used. To isolate the impact of the source of therapist narratives on findings, the present study used a participant sample and methodology similar to that used in Tellides and colleagues (2006), varying only the source of therapist narratives. In the Tellides and colleagues study, therapist narratives

were drawn from within psychotherapy sessions and in the present study, therapist narratives were obtained through a PCE interview conducted by an outside interviewer.

The findings of the present study are different from those of the Tellides and colleagues (2006) study in one critical way: the valence of the complementary relationship patterns found in the W and RO components was inversed. In the present study, the therapist was devalued and others were idealized, while in the first study, the therapist was idealized and others were devalued. Stated in terms of the methodological difference between the two studies: When therapist narratives were relayed directly to the therapist, clients expressed an idealization of the therapist and a devaluation of significant others; when therapist narratives were shared with an outside interviewer, clients expressed a devaluation of the therapist and an idealization of significant others.

As there was a 73% overlap in the participants sampled in both studies, it is reasonable to assume that the divergence in findings is due to the different source of therapist narratives used in each study.

Data drawn from psychotherapy sessions and interviews rely on clients' self-report, and, as such, are vulnerable to the influence of social desirability, or the participants' wish to present themselves in a way that is normatively or socially appropriate (Heppner, Kivlighan, & Wampold, 1999). In Tellides and colleagues (2006), clients may have expressed idealization of the therapist relative to significant others because they believed it was desirable to do so in the therapist's presence. In contrast, clients in the present study may have chosen to express idealization of others relative to the therapist because they feared the inverse might indicate to an outside interviewer that the therapist was personally important to them, exposing their interest or need for

therapy, and casting them in an unfavorable light. Although there is no data available to confirm these speculations about the role of social desirability in these studies, the difference between the two findings suggests clients describe relationships differently, depending on their audience.

The source of therapist narratives also influences inclusion criteria for participants in transference studies. Eight of the participants included in this study shared therapist narratives during PCE interviews, but did not share therapist narratives in-session, precluding their participation in the Tellides and colleagues (2006) study. As previously discussed, there may be important differences between clients who discuss the therapeutic relationship with the therapist and those who do not. For instance, it is possible that clients who have a strong negative reaction toward the therapist elect not to discuss the therapeutic relationship with the therapist. Thus, the additional participants included in the present study could potentially be composed entirely of clients who do not consider their therapists as valuable relative to others in their lives, shifting the factor structure of the CCRT components to indicate a pattern of idealizing others and devaluing the therapist.

Another important consideration with regard to drawing therapist narratives from interviews is the impact the interview protocol may have on the clients' description of the therapist and therapeutic relationship. For instance, the PCE interview protocol required clients to first consider a *good* relationship with someone who is important to them outside of therapy and to describe "what was it that started to get this relationship going on the right track?" By the time the clients were asked about the therapeutic relationship further on in the interview, they may have been primed for delivering a response that was

different from that which they gave for the "good" relationship with a significant other-given that the therapist is in a very different category of relationship. Thus, although the interviewer asked for examples of both positive and negative counsellor characteristics, clients may have described the therapeutic relationship in contrast to the *good* significant-other relationship they described earlier. Additionally, social psychology research has demonstrated that negative stimuli are more powerful than positive stimuli and in relationships, negative episodes seem to be recalled more readily and weighted more heavily than positive ones. (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001; Rozin & Royzman, 2001). It is possible that because clients were cued to remember negative counsellor behaviors and characteristics, more negative or devaluing comments about the therapist were shared in the interviews than in the sessions.

The PCE interview was specifically designed to access significant events in the formation of the therapeutic relationship (e.g. "What has been really important to you in getting your relationship started with your counsellor?"), and is subtly oriented to accessing positive events or "good times" in the relationship (see question 17, Appendix B). However, the findings from the interview data suggest that despite this positive bias in the protocol, clients contributed a number of narratives that were somewhat devaluing of the therapist and the therapeutic relationship. In line with the findings regarding the predominance of negative recall (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001; Rozin & Royzman, 2001), it is possible that the protocol's orientation to significant events cued clients to recall more heavily-weighted negative memories over positive ones. However, there is not clear evidence of these mechanisms in the data, and any discussion regarding the impact the PCE's protocol may have had on transference

findings is merely speculative at this time. It is also difficult to establish whether the interviews actually provided the *high quality* therapist narratives they were designed to elicit from participants, as well as the effect such quality narratives may have had on the findings.

Limitations

The present study's methodological contributions to transference research hinge on the viability of the comparison with Tellides and colleagues' (2000) findings. Although an effort was made to maintain consistency of sample and methodology in order to isolate the impact of the source of therapist narratives, the PCE interview data was not collected at the *exact* same time as the psychotherapy session data. Tellides and colleagues collected therapist narratives from among the first three sessions of therapy, and the PCE interview took place after the third session of therapy. This means that there was a time lag of ten minutes to two weeks between the time some of the last in-session therapist narratives were collected in the first study and the time of the PCE interview. Although this does not represent a substantial amount of time in the course of a treatment, it does introduce a potential confound. In so far as it is possible for client idealization of the therapist to decrease over time and perhaps even within a single session, the differences in the findings of the two studies may be in some part attributable to a sudden shift in relational dynamics between client and therapist. Given this limitation, researchers should use caution in drawing firm conclusions regarding the impact of the source of therapist narratives.

Due to the methodological similarities between this study and the one conducted by Tellides and colleagues (2006), both studies share a number of common limitations:

the specificity of the participant sample, the small sample size, and the focus on early sessions. Details regarding these limitations can be found in Tellides and colleagues, and will only be described briefly here.

The clients involved in this study participated in counselling as an optional component of a counselling course and may not represent the population of high-functioning individuals who initiate treatment for mild to moderate psychological discomfort. The counsellors involved in this study were in training, and their relative inexperience with clients may have had an impact on the manifestation of transference in early therapy. Caution should be used in generalizing these findings to high-functioning consumers of psychological services and to therapies involving more experienced therapists.

Another important limitation common to both studies involves the small sample size. In factor analysis, the stability of the factor structure is contingent on the sample size. The addition of more data may cause variables to switch from one factor to another (Guadagnoli & Velicer, 1988). Although mean communalities were at or above 0.60, indicating that the same factors are likely to be found in the population (MacCallum et al., 2001), it is possible that a larger sample may have suggested a different factor structure and consequently, a different perspective on the manifestation of transference in early therapy.

Finally, this was a study of early psychotherapy sessions, and consequently, the early manifestation of therapeutic transference. It is possible that the complementary transference found early in treatment is an initial phase in the development of a more concordant transference as therapy unfolds. In terms of the impact the timing of the study

may have had on the collection of therapist narratives, it is possible that as therapy progresses and clients feel increasingly comfortable with the therapist and the therapeutic situation, there may be less discrepancy between the narratives shared with the therapist and those collected by an outside interviewer.

Contributions

From a research perspective, the divergence in the findings between the present study and the Tellides and colleagues (2006) study indicate that the *context* in which narratives are shared highly influences the *content* of the narratives. Thus, the source of therapist narratives used in the study of therapeutic transference merits careful consideration, with special attention to the role of social desirability in the collection of therapist narratives and sampling bias related to the source of therapist narratives.

Clinically, the findings from this study indicate that it may be important for therapists to pay attention to how clients organize their experience of the therapeutic relationship vis-à-vis their relationships with significant others. In the early stage of treatment, attention to complementary patterns of transference, in addition to traditionally-prescribed concordant patterns, may effectively inform treatment interventions. Additionally, the difference in findings between the present study and Tellides and colleagues (2006) suggest that therapists should pay close attention to clients' non-verbal and indirect disclosures regarding the therapeutic relationship, as clients may not directly express to the therapist their full experience of the relationship in the early stages of treatment. This information could be useful in understanding client relational issues and helpful in circumventing ruptures to the therapeutic relationship.

The findings also suggest that is important for clinicians to consider how clients may use the therapeutic relationship to work through conflicts between closeness and autonomy they experience with significant others. For instance, it is critical that the therapist determine whether the client may be testing the therapist in the transference, and if so, what the test is about. In that way, therapists may respond to clients' tests in a manner that provides a corrective emotional experience and increases potential for insight and growth in their relationships with significant others.

Future Research Directions

Further CCRT research is necessary to determine the impact of the timing of out-of-session interviews in the collection of therapist narratives, the specificity of the participant sample, the source of therapist narratives, the small sample size, and the focus on early therapy sessions.

Further research is necessary to untangle the influence of the timing of out-of-session interviews on therapist narratives shared by clients. It may be helpful to compare interview data from before and after psychotherapy sessions to determine the impact the progression of treatment may have on client descriptions of the therapist and therapeutic relationship.

Future CCRT transference studies that compare pathological clients with high-functioning clients who initiate treatment could help identify population differences in a way that is more generalizable to consumers of psychological services. The findings of the present study should also be verified using more experienced therapists in order to determine whether therapist experience level significantly impacts the results.

Research directly examining the differences between therapist narratives provided in psychotherapy sessions and those provided in out-of-session interviews would help clarify the impact of these two methods of data collection. Additionally, replication of this research using a larger sample and more data points across the course of therapy would support the validity of these findings and elucidate the impact of timing on the manifestation of transference in general, and on the collection of therapist narratives in particular.

Another useful direction for transference research is to build on existing research using a factor analytic approach to data analysis. CCRT-based transference research has typically examined overlap in clients' most prevalent patterns of CCRT *themes* (i.e. units including Wishes, Responses of Other and Responses of Self) for the therapist and significant others (Fried et al., 1992; Connolly et al., 1996; Connolly et al., 2000). It would be useful to conduct factor analyses that include all three components of the CCRT so as to explore areas of concordant and complementary transference within and across the Ws, ROs, and RSs. As this would involve a greater number of variables, a larger sample size would be necessary for this research.

Similarly, factor analysis could also be used to elucidate the complementary and concordant transference patterns that emerge for the therapist and specific objects in clients' lives. This would illustrate more clearly which transferential dynamics (e.g. parental, fraternal, erotic) are activated with the therapist as a relational overlap, and which are activated as a relational complement to the client's outside experience.

Conclusion

Across therapeutic modalities, clinicians use the construct of therapeutic transference to inform case conceptualization and treatment interventions. It enlightens clinicians about clients' relational problems outside of therapy and infuses treatment with experiential opportunities to work through those difficulties. Transference researchers must continue to study this influential construct carefully, with particular attention to the sources used for the collection of therapist relational data, so as to improve its utility and effectiveness in clinical practice.

References

Barber, J. P., Crits-Christoph, P., & Luborsky, L. (1998). A guide to the CCRT standard categories and their classification. In: *Understanding transference: The Core Conflictual Relationship Theme method* (2nd ed.). L. Luborsky; P. Crits-Christoph; Washington, DC: American Psychological Association, 1998, pp. 43-54.

Barber, J. P., Foltz, C., DeRubeis, R. J., & Landis, J. R. (2002). Consistency of interpersonal themes in narratives about relationships. *Psychotherapy Research, 12*, 139-158.

Battle, C. C., Imber, S. D., Hoehn-Saric, R., Strone, A. R., Nash, E. H., & Frank, J. D. (1966). Target complaints as criteria for improvement. *American Journal of Psychotherapy, 20*, 184-192.

Baumeister, R. F., Bratslavsky, E., Finkenauer, C., & Vohs, K. D. (2001). Bad is stronger than good. *Review of General Psychology, 5*, 4, 323 – 370.

Beitman, B. D. (2005). To the editor: Defining core processes of psychotherapy. *American Journal of Psychiatry, 162*, 8, 1549-1550.

Benjamin, J. (1995). Sameness and difference: Towards an "overinclusive" model of gender development. *Psychoanalytic Inquiry, 15*, 125-142.

Benjamin, L. S. (1974). Structural analysis of social behavior. *Psychological Review, 81*, 392-425.

Bouchard, M-A., Audet, C., St-Armand, P., Perry, J. C., Picard, C., & Wiethaeuper, D. (1997). *Towards a multidimensional monitoring of the psychoanalytic process:*

The Montreal transference countertransference measure. Paper presented at the 20th Ulm Workshop on Empirical Research in Psychoanalysis, Ulm, Germany.

Bowlby, J. (1979). *The making and breaking of affectional bonds.* London: Tavistock.

Chance, S. E., Bakemann, R., Kaslow, N. J., Farber, E., & Burge-Callaway, K. (2000). Core conflictual relationship themes in patients diagnosed with borderline personality disorder who attempted, or who did not attempt, suicide. *Psychotherapy Research, 10*, 337-355.

Chandler, L. A., & Gallagher, R. P. (1996). Developing a taxonomy for problems seen at a university counseling center. *Measurement and Evaluation in Counseling and Development, 29*, 4-12.

Cierpka , M., Strack, M., Benninghoven, D., Staats, H., Dahlbender, R., Pokorny, D., Frevert, G., Blaser, G., Kachele, H., Geyer, M., Komer, A., & Albani, C. (1998). Stereotypical relationship patterns and psychopathology. *Psychotherapy and Psychosomatics, 67*, 241-248.

Connolly, M. B., Cris-Christoph, P., Barber, J. P., & Luborsky, L. (2000). Transference patterns in the therapeutic relationship in supportive-expressive psychotherapy for depression. *Psychotherapy Research, 10*, 356-372.

Connolly, M. B., Crits-Christoph, P., Demorest, A., Azarian, K., Muenz, L., & Chittams, J.(1996). Varieties of transference patterns in psychotherapy. *Journal of Consulting* and Clinical Psychology, 64, 1213-1221.

Crits-Christoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists interpretations and the outcome of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 56*, 4, 490-495.

Crits-Christoph, P., Demorest, A., & Connolly, M. B. (1990). Quantitative assessment of interpersonal themes over the course of psychotherapy. *Psychotherapy, 27*, 513-521.

Crits-Christoph, P., Luborsky, L., Dahl, L., & Popp, C. (1988). Clinicans can agree in assessing relationship patterns in psychotherapy: The Core Conflictual Relationship Theme method. *Archives of General Psychiatry, 45*, 1001-1004.

Diguer, L., Lefebvre, R., Drapeau, M., Luborsky, L., Rousseau, J.-P., Hebert, E., Daoust, J.-P., Pelletier, S., Scullion, M., & Descoteaux, J. (2001). The core conflictual relationship theme of psychotic, borderline, and neurotic personality organizations. *Psychotherapy Research, 11*, 169-186.

Drapeau, M., & Perry, J. C. (2004). Childhood trauma and adult interpersonal functioning: a study using the Core Conflictual Relationship Theme Method (CCRT). *Child Abuse and Neglect, 28,* 1049-1066.

Drapeau, M., DeRoten, Y., & Korner, A. C. (2004). An exploratory study of child molester's relationship patterns using the Core Conflictual Relationship Theme Method. *Journal of Interpersonal Violence, 19, 2*, 264-275.

Dunkle, J. H., & Friedlander, M. L. (1996). Contribution of therapist experience and personal characteristics to the working alliance. *Journal of Counseling Psychology, 43*, 456-460.

Field, A. (2005). *Discovering statistics using SPSS*, (2nd edition). Thousand Oaks, CA: Sage Publications.

Fitzpatrick, M., & Chamodraka, M. (submitted). Participant Critical Events: A multi-perspective method for identifying and isolating significant therapeutic incidents.

Foreman, S. A. (1996). The significance of turning passive into active in control mastery theory. *Journal of Psychotherapy Practice and Research, 5*, 2, 106-121.

Fried, D., Crits-Christoph, P., & Luborsky, L. (1992). The first empirical demonstration of transference in psychotherapy. *Journal of Nervous and Mental Disease, 180*, 5, 326-331.

Freud, A. (1990). Transference. In A. H. Esman (Ed.), *Essential papers on transference*. New York: New York University Press. (original work published in 1936).

Freud, S. (1909). *Five lectures on psychoanalysis*, Standard Edition 11, London : Hogarth Press.

Gaston, L., Goldfried, M. R., Greenberg, L. S., Horvath, A. O., Raue, P. J., & Watson, J. (1995). The therapeutic alliance in psychodynamic, cognitive-behavioral, and experiential therapies. *Journal of Psychotherapy Integration, 5*, 1, 1-26.

Gelso, C. J., & Carter, J. A. (1994). Components of the Psychotherapy Relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*, 3, 296-306.

Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship*. New York: Wiley

Gelso, C. J., Hill, C. E., Mohr, J. J., Rochlen, A. B., & Zack, J. (1999). Describing the face of transference: Psychodynamic therapists' recollections about transference in cases of successful long-term therapy. *Journal of Counseling Psychology, 46*, 257-267.

Guadagnoli, E., & Velicer, W. F. (1988). Relation of sample size to the stability of component patterns. *Psychological Bulletin, 103*, 2, 265-275.

Heppner, P. P., Kivlighan, D. M., & Wampold, B. E. (1999). *Research design in*

counseling (2nd ed.). Belmont, CA: Wadsworth Publishing Company.

Horowitz, M. J. (1989). Relationship schema formulation: Role relationship models and intrapsychic conflict. *Psychiatry, 52*, 260-274.

Horowitz, M. J. (1994). Configurational analysis and the use of relationship models to understand transference. *Psychotherapy Research, 4*, 184-196.

Horowitz, M. J., Merluzzi, T. V., Ewert, M., Ghannam, J. H., Hartley, D., & Stinson, C. H. (1991). Role-relationship models configuration. In M. J. Horowitz (Ed.), *Person schemas and maladaptive interpersonal patterns* (pp. 115-154). Chicago: University of Chicago Press.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In: *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients*. Norcross, John C.; New York, NY: Oxford University Press, pp. 37-69.

Horvath, A. O., & Greenberg, L. S. (Eds.) (1994). *The working alliance: Theory, research, and practice.* New York: John Wiley & Sons. pp. 1-9

Horvath, A. O., & Symonds, D. (1991). Relationship between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139-149.

Kaiser, H. F. (1960). The application of electronic computers to factor analysis. *Educational and Psychological Measurement, 20*, 141-151.

Kelly, G. A. (1955). *The psychology of personal constructs* (Vol. 1). New York: Norton.

Kiesler, D. J., & Schmidt, J. A. (1993). *The Impact Message Inventory: Form IIA Octant Scale Version.* Palo Alto, CA: Mind Garden

Kivlighan, D., Patton, M. J., & Foote, D. (1998). Moderating effects of client attachment on the counselor experience-working alliance relationship. *Journal of Counseling Psychology, 45*, 3, 274-278.

Levine, F. J., & Luborsky, L. (1981). The Core Conflictual Relationship Theme Method: A demonstration of reliable clinical inferences by the method of mismatched cases. In S. Tuttmen, C. Kaye, and M. Zimmerman (Eds.), *Object and self: A developmental approach.* New York: International Universities Press.

Luborsky, L. (1977). Measuring a pervasive psychic structure in psychotherapy: The Core Conflictual Relationship Theme. In N. Freedman & S. Grand (Eds.), *Communicative structures and psychic structures* (pp. 367-395), New York: Plenum Press

Luborsky, L. (1998). Why each CCRt procedure was chosen. In L. Luborsky and P. Crits-Christoph (Eds.) *Understanding Transference: The Core Conflictual Relationship Theme method.* (2nd ed.). (pp. 121-132). Washington DC: American Psychological Association

Luborsky, L., Barber, J. P., Schaffler, P., & Cacciola, J. (1998). The narratives told during psychotherapy and the types of CCRT's within them. In L. Luborsky and P. Crits-Christoph (Eds.) *Understanding Transference: The Core Conflictual Relationship Theme method.* (2nd ed.). (pp. 135-150). Washington DC: American Psychological Association

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding Transference: The Core Conflictual Relationship Theme method.* New York: Basic Books.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding Transference: The Core*

Conflictual Relationship Theme method. (2nd ed.). Washington DC: American Psychological Association

Luborsky, L., Crits-Christoph, P., & Mellon, J. (1986). Advent of objective measures of the transference concept. Special Issue: Psychotherapy Research. *Journal of Consulting and Clinical Psychology, 54*, 39-47.

Luborsky, L. & Diguer, L. (1998). The reliability of the CCRT measure: Results from eight samples. In L. Luborsky and P. Crits-Christoph (Eds.), *Understanding Transference: The Core Conflictual Relationship Theme Method* (2nd ed.). Washington DC: American Psychological Association.

Luborsky, L., Diguer, L., Andrusyna, T., Friedman, S., Tarca, C., Popp, C. A., Ermold, J., & Silberschatz, G. (2004). A method of choosing CCRT scorers. *Psychotherapy Research, 14*, 127-134.

Luborsky, L., Mellon, J., van Ravenswaay, P., Childress, A. R., Cohen, K. D., Hole, A. V., Ming, S., Crits-Christoph, P., Levine, F. J., & Alexander, K. (1985). A verification of Freud's grandest clinical hypothesis: The transference. *Clinical Psychology Review, 5*, 231-246.

Luborsky, L., Popp, C., & Barber, J. P. (1994). Common and special factors in different transference-related measures. *Psychotherapy Research, 4*, 277-286.

MacCallum, R. C., Widaman, K. F., Zhang, S., & Hong, S. (1999). Sample size in factor analysis. *Psychological Methods, 4*, 84-99.

MacCallum, R. C., Widaman, K. F., Preacher, K. J., & Hong, S. (2001). Sample size in factor analysis: The role of model error. *Multivariate Behavioral Research, 36*, 611-637.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

Meissner, W. W. (2001). A note on transference and alliance: II. Patterns of interaction. *Bulletin of the Menninger Clinic, 65*, 2, 219-245.

Mermelstein, J. J (2000). The role of concordance and complementarity in psychoanalytic treatment. *Psychoanalytic Psychology, 17*, 4, 706-729.

Paivio, S. C., & Bahr, L. M. (1998). Interpersonal problems, working alliance, and outcome in short-term experiential therapy. *Psychotherapy Research, 8*, 392-407.

Popp, C. A., Luborsky, L., Andusyna, T. P., Cotsonis, G., & Seligman, D. (2002). Relationships between God and people in the bible: A core conflictual relationship theme study of the Pentateuch/Torah. *Psychiatry, 65*, 179-196.

Rozin, P., & Royzman, E. B. (2001). Negativity bias, negativity dominance, and contagion. *Personality and Social Psychology Review, 5*, 296 – 320.

Schacht, T. & Binder, J. (1982). Focusing: A manual for identifying a circumscribed area of work for time-limited dynamic psychotherapy (TLDP). Unpublished Manuscript, Vanderbilt University.

Schacht, T. E., & Henry, W. P. (1994). Modeling recurrent patterns of interpersonal relationship with structural equation analysis of social behavior. The SASB-CMP. *Psychotherapy Research, 4*, 208-221.

Sexton, H. C., Hembre, K., & Kvarme, G. (1996). The interaction of the alliance and therapy microprocesses: A sequential analysis. *Journal of Consulting and Clinical Psychology, Vol 64*, 3, 471-480.

Shrout, P. E., & Fleiss, J. L. (1979). Intraclass correlations: Uses in assessing rater reliability. *Psychological Bulletin, 86*, 420-428.

Stevens, J. (1996). *Applied multivariate statistics for the applied social sciences*, (3rd ed.). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Strupp, H. H., & Binder, J. L. (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy*. New York: Basic Books.

Tellides, C., Fitzpatrick, M., Drapeau, M., & Bracewell, R., Janzen, J., & Jaouich, A. (2006). *The manifestation of transference in the formation of the therapeutic relationship: Study of a high-functioning population.* Unpublished manuscript. McGill University, Montreal, Quebec.

Tomkins, S. (1979). Script theory: Differential magnification of affects. In H. E. Howe, Jr., & R. A. Diensbier (Eds.), *Nebraska symposium on motivation* (Vol. 26, pp. 201-236). Lincoln: University of Nebraska Press.

Waldinger, R. J., Diguer, L., Guastella, F., Lefebvre, R., Allen, J. P., Luborsky, L., & Hauser, S. T. (2002). The same old song?—Stability and change in relationship schemas from adolescence to young adulthood. *Journal of Youth and Adolescence, 31*, 17-29.

Waldinger, R. J., Toth, S. L., & Gerber, A. (2001). Maltreatment and internal representations of relationships: Core relationship themes in the narratives of abused and neglected preschoolers. *Social Development, 10*, 41-48.

Weiss, J. (1994). The analyst's task: To help the patient carry out his plan. *Contemporary Psychoanalysis, 30*, 2, 236-254.

Weiss, J. & Sampson, H. (1986). *The psychoanalytic process: Theory, clinical*

observations and empirical research. New York: Guilford Press.

Westen, D. (2000). *Psychotherapy Relationship Questionnaire (PRQ) Manual.* Available at http://www.psychsystems.net/lab.

Wilczec, A., Weinryb, R. M., Barber, J. P., Gustavsson, J. P., & Asberg, M. (2004). Change in the core conflictual relationship theme after long-term dynamic psychotherapy. *Psychotherapy Research, 14*, 1, 107-125.

Wilczec, A., Weinryb, R. M., Barber, J. P., Gustavsson, J. P., & Asberg, M. (2000). The core conflictual relationship theme (CCRT) and psychopathology in patients selected for dynamic psychotherapy. *Psychotherapy Research, 10*, 100-113.

Table 1

Means, Standard Deviations and Ranges for Each W, RO and RS Cluster (N = 30)

Clusters	M (SD)	Range
Wishes		
OWC1: To assert self and be independent with others	0.97 (0.70)	2.04
OWC2: To oppose, hurt and control others	0.50 (0.68)	1.78
OWC4: To be distant and avoid conflict with others	1.42 (0.50)	2.04
OWC5: To be close and accepting with others	1.42 (0.71)	2.46
OWC6: To be loved and understood by others	1.49 (0.58)	2.32
OWC7: To feel good and comfortable with others	0.94 (0.77)	2.04
OWC8: To achieve and help others	1.47 (0.45)	2.00
TWC3: To be controlled, hurt, not responsible with the therapist	0.29 (0.49)	1.30
TWC4: To be distant and avoid conflict with the therapist	0.41 (0.61)	1.60
TWC5: To be close and accepting with the therapist	1.15 (0.64)	2.18
TWC6: To be loved and understood by the therapist	1.05 (0.61)	2.00
TWC7: To feel good and comfortable with the therapist	0.35 (0.60)	1.48
TWC8: To achieve and help the therapist	0.72 (0.67)	1.78
Responses of Other		
OROC1: Others are strong	1.24 (0.50)	1.85
OROC2: Others are controlling	1.08 (0.68)	2.04
OROC4: Others are bad	1.13 (0.59)	1.95

OROC5: Others are rejecting and opposing	2.09 (0.34)	1.56
OROC7: Others like me	1.56 (0.56)	2.38
TROC1: Therapist is strong	0.89 (0.64)	1.85
TROC2: Therapist is controlling	0.18 (0.42)	1.48
TROC3: Therapist is upset	0.44 (0.66)	1.85
TROC5: Therapist is rejecting and opposing	0.68 (0.68)	1.90
TROC6: Therapist is helpful	1.43 (0.58)	2.15
TROC7: Therapist likes me	1.35 (0.49)	2.18
Responses of Self		
ORSC2: Unreceptive with others	1.70 (0.70)	2.36
ORSC4: Oppose and hurt others	1.59 (0.65)	2.36
ORSC6: Helpless with others	1.63 (0.34)	1.34
TRSC1: Helpful with therapist	1.70 (0.32)	1.36
TRSC2: Unreceptive with therapist	0.74 (0.69)	1.90
TRSC3: Respected and accepted with therapist	1.71 (0.39)	1.32
TRSC5: Self-controlled and self-confident with therapist	0.65 (0.64)	1.60
TRSC6: Helpless with therapist	0.41 (0.61)	1.70
TRSC7: Disappointed and depressed with therapist	0.77 (0.68)	1.78
TRSC8: Anxious and ashamed with therapist	0.65 (0.65)	1.70

Note. OWC = other Wish cluster; TWC = therapist Wish cluster; OROC = other Response of Other cluster; TROC = therapist Response of Other cluster; ORSC = other Response of Self cluster; TRSC = therapist Response of Self cluster.

Table 2

Summary of Items and Factor Loadings for Varimax Orthogonal Four-Factor Solution for Therapist and Other Wish Clusters ($N = 30$)

Cluster	Factor Loading 1	2	3	4	Communality
Ambivalent Wishes With Others					
OWC5: To be close and accepting with others	**.75**	-.04	.12	-.44	.77
OWC2: To oppose, hurt and control others	**.65**	.06	.02	.32	.53
OWC1: To assert self and be independent with others	**.59**	.12	.50	-.03	.61
OWC6: To be loved and understood by others	**.56**	.02	-.13	-.05	.34
OWC4: To be distant and avoid conflict with others	**.48**	.05	.34	.39	.50
Positive Wishes With Therapist					
TWC5: To be close and accepting with the therapist	-.22	**.86**	.05	.08	.79
TWC8: To achieve and help the therapist	.18	**.77**	-.15	-.23	.70
TWC6: To be loved and understood by the therapist	.15	**.69**	-.02	.25	.55

Wish To Feel Good And Comfortable With Others, Not With Therapist					
OWC7: To feel good and comfortable with others	.11	.24	**.81**	.24	.78
OWC8: To achieve and help others	.11	-.17	**.68**	-.16	.52
TWC7: To feel good and comfortable with the therapist	.29	.32	**-.55**	.19	.53
Wish To Be Submissive With Therapist					
TWC3: To be controlled, hurt, and not responsible with the therapist	-.09	.00	-.03	**.80**	.64
TWC4: To be distant and avoid conflict with the therapist	.25	.23	-.43	**.48**	.53

Note. Boldface indicates highest factor loadings. OWC = other Wish cluster; TWC = therapist Wish cluster.

Table 3

Summary of Items and Factor Loadings for Varimax Orthogonal Four-Factor Solution for Therapist and Other RO Clusters ($N = 30$)

Cluster	Factor Loading 1	2	3	4	Communality
Ambivalent Responses From Therapist					
TROC5: Therapist is rejecting and opposing	**.80**	.11	.01	.13	.68
TROC6: Therapist is helpful	**.77**	-.16	-.06	-.08	.63
TROC1: Therapist is strong	**.61**	.44	-.18	.15	.63
TROC7: Therapist likes me	**.57**	-.18	.47	.11	.60
Negative Responses From Others					
OROC2: Others are controlling	-.19	**.88**	.06	.00	.82
OROC5: Others are rejecting and opposing	.18	**.72**	.14	-.07	.58
Positive Responses From Others					
OROC7: Others like me	-.10	.13	**.77**	-.05	.61
OROC1: Others are strong	-.05	.51	**.58**	.12	.61

Negative Responses From Therapist, Not From Others					
OROC4: Others are bad	.09	.16	.41	**-.79**	.83
TROC3: Therapist is upset	.15	.26	.26	**.65**	.58
TROC2: Therapist is controlling	.29	-.37	.44	**.55**	.72

Note. Boldface indicates highest factor loadings. OROC = other Response of Other cluster; TROC = therapist Response of Other cluster.

Table 4

Summary of Items and Factor Loadings for Varimax Orthogonal Two-Factor Solution for Therapist and Other RS Clusters (N = 30)

Cluster	Factor Loading 1	2	Communality
Ambivalent Responses To Therapist			
TRSC6: Helpless with therapist	**.82**	-.03	.67
TRSC3: Respected and accepted with therapist	**.78**	-.02	.61
TRSC1: Helpful with therapist	**.76**	-.41	.75
TRSC8: Anxious and ashamed with therapist	**.73**	-.09	.54
TRSC2: Unreceptive with therapist	**.72**	.28	.59
TRSC7: Disappointed and depressed with therapist	**.48**	-.18	.26

Feel Bad With Others, Feel Bad With Therapist			
ORSC2: Unreceptive with others	.13	**.81**	.67
ORSC6: Helpless with others	-.18	**.78**	.64
ORSC4: Oppose and hurt others	-.00	**.75**	.56
TRSC5: Self-controlled and self-confident with therapist	.46	**-.66**	.65

Note. Boldface indicates highest factor loadings. ORSC = other Response of Self cluster; TRSC = therapist Response of Self cluster.

Concluding Discussion

In an article addressing the lack of theoretical and empirical consensus in the field of psychology, Goldfried (2000) highlights four areas of miscommunication: the gap between research and practice, differing theoretical approaches, language barriers in the field, and variations in research methodology. Constantino and Castonguay (2003) echo Goldfried's concerns regarding the gaps between science and practice and also assert the necessity for cross-discipline integration. As with all new contributions to the field, the research presented in this dissertation is vulnerable to systemic challenges and also represents an opportunity to overcome them. The following discussion will address the implications of this research with an eye on providing bridges across psychological disciplines and between theoretical approaches.

Research Contributions

Important yet elusive psychological constructs present an irresistible challenge to researchers who are committed to negotiating the tension between methodological rigor and clinical relevance. Transference is such a concept, and has long-seduced researchers in the field of psychotherapy research, and more recently those in the area of socio-cognitive research. Although cross-fertilization between the research efforts of both disciplines would greatly improve our understanding of transference, little integration exists at this time (Andersen & Adil, 2006). Gabbard (2006) also suggests there are strong links between the concept of transference and existing research in cognitive neuroscience. The results of the present studies will be examined in the context of empirical findings in socio-cognitive psychology and cognitive neuroscience.

Socio-cognitive studies on transference have found evidence that individuals use mental representations of significant others to interpret new individuals in everyday life (Andersen & Baum, 1994; Andersen & Cole, 1990; Andersen et al., 1996; Hinkley & Andersen, 1996). Researchers in this field have also found that transference is more likely to occur when the new individual resembles a significant other, and less likely to occur when environmental cues and specific aspects of the new person are incongruent with mental representations of significant-others (Anderson & Cole, 1990; Anderson et al., 1995; Berk & Andersen, 2000). This last finding is of particular relevance to the study of therapeutic transference, as therapy is likely to offer environmental cues different from those experienced in the outside world.

Psychotherapy research on transference has also found evidence of the repetition of relational themes across different relationships as well as an overlap between relational patterns that emerge with significant others and those that emerge with the therapist (Fried et al., 1992; Connolly et al., 1996; Connolly et al., 2000). However, the research presented in this paper indicates that therapeutic transference may also manifest itself in complementary patterns between the therapist and significant others. Socio-cognitive researchers Andersen and Berk (1998) comment on the value of using therapeutic transference to help change clients' real-world transference responses, but caution against interpretation of transference that does not take into account the unique treatment-specific aspects of the therapeutic relationship (i.e. treatment structures and client expectancies). Rather than assume that only one generalized significant-other representation emerges across all encounters, clinicians and researchers are urged to consider that a blend of "synonym" (concordant) and "antonym" (complementary) significant-other

representations may be activated, depending on context-specific factors (Andersen & Berk, 1998, p. 86).

Data from the field of cognitive neuroscience also corroborate the existence of multiple transferences that are based on context-specific cues (Gabbard, 2002, 2006). Cognitive neuroscience research has identified a process of "pattern matching" which involves the evocation of neural patterns that are similar to a configuration representing previous encounters with others and associated feeling states (Gabbard, 2006, p. 284). The likelihood of pattern matching is contingent upon the strength of the association between information previously stored within a neural network and new information entering the network. Situations that depart from normal social discourse, such as the asymmetrical set up of psychotherapy, activate a range of responses in the client that may not necessarily parallel transference constellations that exist in the client's outside world (Gabbard, 2006). Thus, research in the areas of socio-cognitive and cognitive neuroscience confirms some key findings in the present studies.

The participant sample used in any research project has the capacity to greatly impact findings. In transference research, which is focused on client relational patterns, the client participants are of particular relevance. Psychotherapy process research studies of transference have historically used a pathological patient population to study relationship pattern repetition. Studies within the field of cognitive neuroscience have studied both normal and pathological populations (Gabbard, 2006), and the field of socio-cognitive transference research generally involves high-functioning, non-pathological participants (Andersen & Berk, 1998). In contrast to previous CCRT transference research, the participants in the present studies were high-functioning students, without

any known psychiatric diagnoses. Although previous psychotherapy research with pathological clients indicated a pattern of relational overlap consistent with traditional conceptualizations of transference, the present studies demonstrate the presence a complementary transference pattern that is supported in socio-cognitive and cognitive neuroscience studies using nonpathological participant samples.

Although the results from both studies presented in this paper contradict previous CCRT research on transference, there are a number of findings in fields outside psychotherapy research that lend support to the notion of a therapeutic transference that does not involve a direct overlap in relational patterns between the therapist and significant others for high-functioning individuals. Integration of methods and findings across the fields of cognitive neuroscience, socio-cognitive, and psychotherapy research may be quite helpful in guiding researchers towards a more subtle examination of *how* (in what way) and *when* (under what circumstances) transference manifests itself in therapy.

Within the realm of psychotherapy research, transference-related processes have been studied from a variety of theoretical perspectives (constructivist: *Role Construct Repertory*, Kelly, 1955; interpersonal: *Impact Message Inventory*, Kiesler & Schmidt, 1993; narrative: *Personal Scripts*, Tompkins, 1979; object relations: *Montreal Transference and Countertransference Measure*, Bouchard et al., 1997 and *Psychotherapy Relationship Questionnaire*, Westen, 2000). Although the measures are quite different, they all face one common challenge: the collection of relationship data that will serve to guide researchers and clinicians in an accurate understanding of relational phenomena (Luborsky, 1998). Thus, the sources of relationship data and more

specifically, factors that may influence the report of relationship data are of critical relevance to the measurement of transference.

Transference-related measures typically involve therapist, client or observer ratings on data drawn from psychotherapy sessions, interviews and questionnaires. The CCRT involves observer ratings on client self-report data from psychotherapy sessions and interviews. The primary purpose of the second study in this project was to explore therapeutic transference using an alternative source of therapist narratives to those typically used in CCRT transference research. In the first study (as in previous CCRT studies of transference), therapist narratives were culled from within psychotherapy sessions, where they were relayed to the therapist. In the second study, therapist narratives were drawn from a *Participant Critical Event* (PCE; Fitzpatrick & Chamodraka, submitted) interview that was conducted by an outside interviewer. Reasoning that clients would feel less inhibited discussing the therapeutic relationship with an outside interviewer, the interview was designed as a situation that paralleled the therapy sessions, from which narratives about others were drawn. Although both studies yielded a similar overall pattern of complementary and concordant transference, there was an inversion in the valence of the complementary transference that could be reasonably attributed to the source of therapist narratives, as that was the single greatest methodological difference between the two studies.

The mechanism by which the source of therapist narratives influenced the results is not entirely clear. The differences in findings may be attributable to social desirability factors in the self-reported relational narratives, the potential sampling bias inherent in including participants who do not discuss the therapeutic relationship with the therapist

(i.e. participants who only contributed therapist narratives during the PCE interview), or to the specific structure of the PCE interview. However, one clear implication of these findings is that source of relational data substantially impacts the results of transference research, and merits close attention in future studies of this phenomenon, regardless of type of measurement or theoretical leanings.

Clinical Contributions

The term *transference* has its origins in psychoanalytic theory, but as presented elsewhere in this paper, the concept of transference has a counterpart in several theoretical orientations. Across therapeutic modalities, therapists' construal of the therapeutic relationship relative to other important relationships in clients' lives has an impact on case conceptualization, treatment planning, therapeutic interventions, and in so far as it is intertwined with therapeutic alliance, it may also impact therapy outcome. It is a powerful tool clinicians use to understand clients' expectations of and responses to significant others in their lives. Short of inviting clients' significant others into the therapy room, therapeutic transference is one of the few ways many therapists hope to experience the client in relation to others (Fonagy, 1999). Thus, findings on the manifestation of transference in the early stages of relationship formation in therapy can be useful to all clinicians who wish to gain an understanding of how client's extra-therapeutic relationships influence this critical stage of the therapeutic process.

Among psychoanalytic theorists, transference has been described as the displacement of psycho-sexual conflicts (Freud 1912), neurotic trends (Horney, 1939), parataxic distortions (Sullivan, 1953), and a variety of other terms reflecting the theoretical mechanisms of specific psychoanalytic models. The use of transference

interpretations in analytically-informed treatments is aimed at facilitating the client's discovery of conflictual motivations that have been warded off from the client's conscious awareness. The function of these interpretations is to reduce resistance in treatment and foster resolution of displaced conflicts.

In cognitive therapies, the term "transference cognition" is used to describe the automatic and irrational thoughts patients have about the therapist, based on generalized beliefs and expectancies (Beck & Freeman, 1990, p. 65; Freeman et al., 1990). These beliefs require attention, assessment and explicit clarification, so that they do not interfere with the work of treatment. Cognitive therapists are encouraged to be attentive to changes in the patient's non-verbal behavior, pauses in speech, sudden change of topic, and shifts in the patient's gaze, as such patient behaviors may indicate the presence of an automatic thought about the treatment or the therapist (Beck, 1990). Cognitive therapists generally endorse the identification and use transference to understand the meanings and beliefs behind patients' idiosyncratic or repetitious reactions.

Humanistic treatments also attend to therapeutic transference, and use interventions such as reflection, confrontation, and two-chair techniques to increase clients' awareness of unconscious emotional experiences and unfulfilled needs (Castonguay, 2000). These techniques are designed to encourage a new meaning-making process that can guide clients in adopting different ways of relating to themselves, to others, and generally to the difficulties of life

Across theories, therapeutic transference is commonly understood to imply an overlap in relationship patterns between significant others and the therapist, and psychotherapy research has demonstrated that this overlap can occur early in treatment

(Connolly et al., 2000). However, findings of the present research indicate that therapists should also be attentive to the way clients may seek to contrast the therapeutic relationship with outside relationships in early treatment. The assumption that all clients exhibit an overlap in relational patterns in and out of therapy may lead clinicians to draw immature or inappropriate parallels between relational instances in the therapeutic relationship and client relational difficulties outside of treatment. Case conceptualization and interventions built on potentially erroneous presumptions regarding transference may prove ineffective in the management of client problems and detrimental to the therapeutic relationship.

The studies presented in this paper highlight the importance of making a concerted effort to use methods that will uncover what actually occurs in treatment, rather than what theorists suggest is occurring. The somewhat unexpected findings regarding the manifestation of complementary therapeutic transference highlight the relevance of the cognitive imperative to "stay close to the data" (Freeman et al., 1990, p. 195). Although the focus of this discussion has been on the complementary transference uncovered in the findings, it is important to note that this research also demonstrated an overlap in negative client responses to the therapist and others and also identified an emergence of control issues in treatment. These additional findings highlight the complexity of the transference construct and lend credibility to the dynamic focus of exploring issues that cut across different times and situations in a patient's life, including the issues that emerge with the therapist (Castonguay, 2000).

General Limitations and Directions for Future Research

While the preceding discussion considered the research findings from this project at face-value, a number of methodological shortcomings that limit the generalizability of the results merit elaboration. Due to methodological similarity, both studies contain the same three limitations: The specificity of the participant sample, the small sample size, and the focus on early therapy sessions. The clients in these studies participated in counseling as an optional experiential component of a counseling course in an undergraduate program. Findings should be extended to other high-functioning clients with caution and verified in future research using a sample more representative of high-functioning clients who initiate treatment for mild to moderate psychological discomfort.

The counselors participated in these therapies as a training component of a masters-level graduate program in counseling psychology. Although there are mixed findings concerning the impact of therapist experience on the therapeutic relationship, results from these studies should be cautiously extended to therapies with experienced therapists. Future research should verify the present findings using experienced therapists.

The small sample size used in the factor analysis of the data may have generated an unstable factor structure that could potentially shift with a larger sample size. It will be important to verify these findings using a larger sample size.

In both studies, transference was explored in the first three sessions of therapy, and the results may not apply to the manifestation of transference later in treatment. Future studies that compare results across phases of treatment may clarify whether the manifestation of transference is phase-specific.

The second study contained an additional limitation: The PCE interview data were collected anywhere from ten minutes to one week after the last of the session data was collected, therefore it is possible that the therapist devaluation evident in the interviews is an artifact of the passage of time and not due exclusively to the source of narratives. Future research examining session and PCE data over time could verify the influence of timing on the collection of therapist narratives.

Bridging The Gap Between Research, Training and Practice

It has become increasingly clear that psychological research could be better utilized to inform clinical practice (Newman, Castonguay, Berkovec, & Molnar, 2004). Psychotherapy research, in particular, has clear implications for clinical work as it directly focuses on the study of clinical phenomena. Goldfried (2000) argues that the "core" of psychotherapy lies at the point of overlap between research findings and conclusions based on involvement in clinical practice (p. 15).

Individuals interested in the study of therapeutic factors common to all theoretical approaches focus their research efforts on the identification of robust mechanisms of change across all treatments (Castonguay, 2000, p.263). Although clinical experience generally confirms the important role of common factors such as the therapeutic relationship, clinicians are still faced with the challenge of delivering interventions that are suitable for the clients' individual needs (Castonguay, 2000). Because interventions are usually nested within a particular theory, research that focuses exclusively on the broadest category of commonality may be of lesser interest to clinicians. What may be more informative to clinical practice is the study of principles of change that are at a level of abstraction between the common factors and specific theoretical techniques. For

instance, global mechanisms of change such as the facilitation of a corrective experience, the identification of relevant patterns, and the provision of a new view of self can meaningfully guide clinically-relevant research (Castonguay, 2000).

The common factors approach to psychotherapy training outlined by Castonguay (2000) offers a helpful framework for bridging the gap between psychotherapy research and theory-based practice. In Castonguay's training approach, students spend much of the practicum seminar learning about important mechanisms of change from a specific theoretical perspective by examining videotaped sessions and engaging in role-plays. The mechanisms of change are then discussed using the language of other theoretical approaches, thereby demonstrating to students how technical interventions can be substituted as long as they address the same global mechanisms of change and serve the same therapeutic function. As in training and practice, research can lose focus if it does not examine interventions or concepts typically associated with specific theoretical approaches. Yet, research findings would be much more accessible and relevant to clinicians across theoretical approaches if the implications of the findings were translated to clearly demonstrate the universal application of the results to clinical practice.

Transference is a therapeutic concept nested in the psychoanalytic tradition, yet clinicians across theoretical orientations pay attention to and make use of relational patterns that emerge in treatment. Thus, throughout this dissertation, a concerted effort was made to translate transference theory into a language accessible to clinicians of many orientations. The research studies presented in this work were designed to be exploratory and not guided by any particular theoretical assumptions about the manifestation of transference patterns in treatment. These measures were taken in an effort to highlight the

relevance of transference as a global mechanism of change whose clinical utility lies somewhere between the practicality of specific techniques (i.e. identification of relationship patterns) and the ubiquitous resonance of common factors (i.e. centrality of the therapeutic relationship).

In so far as research on transference can be made accessible to clinicians of various theoretical backgrounds, the empirical study of this phenomenon can have a great impact on treatment. However, the study of transference is not an easy task. Transference is a finely nuanced interpersonal process that begins outside of therapy and unfolds with the therapist in complex ways. To capture this phenomenon in a way that will effectively inform practice, researchers must strike a fine balance between scientific rigor and clinical relevance. For decades, transference researchers have shown great innovation in accomplishing that task, and as they continue to improve methodology and identify ways of translating findings across theoretical approaches, therapists and clients alike will benefit from their efforts.

References

Albani, C., Pokorny, D., Blaser, G., Gruninger, S., Konig, S., Marscke, F., Koerner, A.,Geyer, M., & Kachele, H. (2002). Reformulation of the core conflictual relationship theme (CCRT) categories: The CCRT-LU Category System. *Psychotherapy Research, 12*, 3, 319-338.

Albani, C., Benninghoven, D., & Blaser, G., (1999). On the connection between affective evaluation of recollected relationship experience and the severity of the psychic impairment. *Psychotherapy Research, 9*, 4, 452-467.

Andersen, S. M., & Adil, S. S. (2006). Thinking integratively about social psychology: The example of the relational self and the social-cognitive process of transference. In P. A. M. Van Lange (Ed). Bridging social psychology: Benefits of transdisciplinary approaches, (pp. 199-205). Mahwah, NJ: Lawrence Erlbaum Associates.

Andersen, S. M., & Berk, M. S. (1998). Transference in everyday experience: Implications of experimental research for relevant clinical phenomena. *Review of General Psychology, 2*, 1, 81-120.

Andersen, S. M., & Baum, A. (1994). Transference in interpersonal relations: Inferences and affect based on significant-other representations. *Journal of Personality, 62*, 460-497.

Andersen, S. M., & Cole, S. W. (1990). "Do I know you?": The role of significant others in general social perception. *Journal of Personality and Social Psychology, 59*, 384-399.

Andersen, S. M., Glassman, N. S., Chen, S., & Cole, S. W. (1995). Transference in social perception: The role of chronic accessibility in significant-other representations. *Journal of Personality and Social Psychology, 69*, 41-57.

Andersen, S. M., Reznik, I., & Manzella, L. M. (1996). Eliciting transient affect, motivation, and expectancies in transference: Significant-other representation and the self in social relations. *Journal of Personality and Social Psychology, 71*, 1108-1129.

Albani, C., Pokorny, D., Dahlbender, R. W., & Kachele, H. (1994). Vom Zentralen Beziehungs-Konflikt-Thema (ZBKT) zu ZentralenBeziehungsmustern (ZBM). Eine methodenkritische Weiterentwicklung der Methode des "Zentralen-Beziehungs-Konflikt-Themas" *Psychotherapie, Psychosomatik, Medizinische Psychologie, 44*, 89-98.

Alpher, V. S., Perfetto, H. W. P, & Strupp, H. H. (1990). Dynamic factors in client assessment and prediction of change in short-term dynamic psychotherapy. *Psychotherapy, 27*, 350-361.

Arnow, B. A. (2005). Cognitive behavioral analysis system of psychotherapy for chronic depression. *Cognitive and Behavioral Practice, 12*, 1, 6-16.

Asay, T. P., & Lambert, M. J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M. A. Hubble, B. L. Duncan, & S. D. Miller (Eds.). *The heart and soul of change: What works in therapy.* Washington, DC: American Psychological Association.

Barber, J. P., Crits-Christoph, P., & Luborsky, L. (1998). A guide to the CCRT standard categories and their classification. In L. Luborsky and P. Crits-Christoph (Eds.),

Understanding transference: The Core Conflictual Relationship Theme method (2nd ed.), (pp. 43-54). Washington, DC: American Psychological Association.

Barber, J. P., Foltz, C., DeRubeis, R. J., & Landis, J. R. (2002). Consistency of interpersonal themes in narratives about relationships. *Psychotherapy Research, 12*, 139-158.

Barber, J. P., Luborsky, L., Crits-Christoph, P., & Diguer, L. (1995). A comparison of core conflictual relationship themes before psychotherapy and during early sessions. *Journal of Consulting and Clinical Psychology, 63*, 145-148.

Barber, J. P., Luborsky, L., Diguer, L., & Crits-Christoph, P. (1995). A comparison of core conflictual relationship themes before psychotherapy and during early sessions. *Journal of Consulting and Clinical Psychology, 63*, 1, 145-148.

Bartholomew, K. (1997). Adult attachment processes: Individual and couple perspectives. *British Journal of Medical Psychology, 70*, 249-263.

Bartholomew, K. & Horowitz, L. M. (1991). Attachment styles among young adults: A test of a four-category model. *Journal of Personality and Social Psychology, 61*, 226-244.

Battle, C. C., Imber, S. D., Hoehn-Saric, R., Strone, A. R., Nash, E. H., & Frank, J. D. (1966). Target complaints as criteria for improvement. *American Journal of Psychotherapy, 20*, 184-192.

Baumeister, R. F., Bratslavsky, E., Finkenauer, C., & Vohs, K. D. (2001). Bad is stronger than good. *Review of General Psychology, 5*, 4, 323 – 370.

Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York: International Universities Press.

Beck, A. T., & Freeman, A. F. (1990). *Cognitive therapy of personality disorders.* New York: Guilford Press

Beck, A. T., Ward, C. H., Mendelson, M., Mock, J., & Erlbaugh, J. (1961). An inventory for measuring depression. *Archives of General Psychiatry, 4*, 561-571.

Beitman, B. D. (2005). To the editor: Defining core processes of psychotherapy. *American Journal of Psychiatry, 162*, 8, 1549-1550.

Benjamin, J. (1995). Sameness and difference: Towards an "overinclusive" model of gender development. *Psychoanalytic Inquiry, 15*, 125-142.

Benjamin, L. S. (1974). Structural analysis of social behavior. *Psychological Review, 81*, 392-425.

Berk, M. S., & Andersen, S. M. (2000). The impact of past relationships on interpersonal behavior: Behavioral confirmation in the social-cognitive process of transference. *Journal of Personality and Social Psychology, 79*, 4, 546-562.

Bickman, L. (2005). A common factors approach to improving mental health services. *Mental Health Services research, 7*, 1, 1-4.

Bouchard, M-A., Audet, C., St-Armand, P., Perry, J. C., Picard, C., & Wiethaeuper, D. (1997). *Towards a multidimensional monitoring of the psychoanalytic process: The Montreal transference countertransference measure.* Paper presented at the 20th Ulm Workshop on Empirical Research in Psychoanalysis, Ulm, Germany.

Bowlby, J. (1979). *The making and breaking of affectional bonds.* London: Tavistock.

Bradley, R., Heim, A. K., & Westen, D. (2005). Transference patterns in the psychotherapy of personality disorders: Empirical investigation. *British Journal of Psychiatry, 186*, 4, 342-349.

Carter, J. A. (2006). Theoretical pluralism and technical eclecticism. In C. D. Goodheart, A. E. Kazdin, and R. J. Sternberg (Eds.), *Evidence-based psychotherapy: Where practice and research meet.* (pp.63-79). Washington, DC: American Psychologial Association.

Castonguay, L. G. (1993). "Common factors" and "nonspecific variables": Clarification of the two concepts and recommendations for research. *Journal of Psychotherapy Integration, 3*, 3, 267-286.

Castonguay, L. G. (2000). A common factors approach to psychotherapy training. *Journal of Psychotherapy Integration, 10*, 3, 263-282.

Castonguay, L. G., Goldfried, M. R., Wiser, S., Raue, P. J., & Hayes, A. M. (1996). Predicting the effet of cognitive therapy for depression: A study of unique and common factors. *Journal of Counselling Psychology, 64*, 497-504.

Castonguay, L. G., & Grosse Holtforth, M. (2005). Change in psychotherapy: "Nonspecific" and false dichotomies. *Clinical Psychology: Science and Practice, 12*, 2, 198-201.

Chance, S. E., Bakemann, R., Kaslow, N. J., Farber, E., & Burge-Callaway, K. (2000). Core conflictual relationship themes in patients diagnosed with borderline personality disorder who attempted, or who did not attempt, suicide. *Psychotherapy Research, 10*, 337-355.

Chandler, L. A., & Gallagher, R. P. (1996). Developing a taxonomy for problems seen at a university counseling center. *Measurement and Evaluation in Counseling and Development, 29*, 4-12.

Cierpka , M., Strack, M., Benninghoven, D., Staats, H., Dahlbender, R., Pokorny, D.,

Frevert, G., Blaser, G., Kachele, H., Geyer, M., Komer, A., & Albani, C. (1998). Stereotypical relationship patterns and psychopathology. *Psychotherapy and Psychosomatics, 67*, 241-248.

Clarkin, J. F. & Levy, K. N. (2004). The influence of client variables on psychotherapy. In M. J. Lambert (Ed) *Handbook of Psychotherapy and Behavior Change*, 5th ed. NY: John Wiley and Sons.

Clementel-Jones, C., Malan, D., & Trauer, T. (1990). A retrospective follow-up study of 84 clients treated with individual psychoanalytic psychotherapy: Outcome and predictive factors. *British Journal of Psychotherapy, 6,* 363-376.

Connolly, M. B., Cris-Christoph, P., Barber, J. P., & Luborsky, L. (2000). Transference patterns in the therapeutic relationship in supportive-expressive psychotherapy for depression. *Psychotherapy Research, 10*, 356-372.

Connolly, M. B., Crits-Christoph, P., Demorest, A., Azarian, K., Muenz, L., & Chittams, J. (1996). Varieties of transference patterns in psychotherapy. *Journal of Consulting and Clinical Psychology, 64*, 1213-1221.

Connolly, M. B., Crits-Cristoph, P., Shappell, S., Barber, J. P., Luborsky, L., & Shaffer, C. (1999). The relation of transference interpretations to outcome in the early sessions of brief supportive-expressive psychotherapy. *Psychotherapy Research, 9,* 4, 485-495.

Connolly Gibbons, M. B., Crits-Christoph, P., de la Cruz, C., Barber, J. P., Siqueland, L., & Gladis, M. (2003). Pretreatment expectations, interpersonal functioning, and symptoms in the prediction of the therapeutic alliance across supportive-

expressive psychotherapy and cognitive therapy. *Psychotherapy Research, 13*, 59-76.

Constantino, M. J., & Castonguay, L. G. (2003). Learning from basics: Clinical implications of social, developmental, and cross-cultural study of the self. *Journal of Psychotherapy Integration, 13*, 1, 3-8.

Couture, S. M., Roberts, D. L., Penn, D. L., Cather, C., Otto, M. W., & Goff, D. (2006). Do baseline characteristics predict the therapeutic alliance in the treatment of schizophrenia? *Journal of Nervous and Mental Diseases, 194*, 1, 10-14.

Crits-Christoph, P. (1998). The interpersonal interior of psychotherapy. *Psychotherapy Research, 8*, 1-16.

Crits-Christoph, P., Connolly, M. B., Shappell, S., Elkin, I., Krupnick, J., & Sotsky, S. (1999). Interpersonal narratives in cognitive and interpersonal psychotherapies. *Psychotherapy Research, 9*, 22-35.

Crits-Christoph, P., Cooper, A., & Luborsky, L. (1988). The accuracy of therapists interpretations and the outcome of dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 56*, 4, 490-495.

Crits-Christoph, P., Demorest, A., & Connolly, M. B. (1990). Quantitative assessment of interpersonal themes over the course of psychotherapy. *Psychotherapy, 27*, 513-521.

Crits-Christoph, P., & Luborsky, L. (1990). Changes in CCRT pervasiveness during psychotherapy. In L. Luborsky and P. Crits-Christoph (Eds.), *Understanding Transference: The Core Conflictual Relationship Theme method.* (pp. 133-146). New York: Basic Books.

Crits-Christoph, P., Luborsky, L., Dahl, L., & Popp, C. (1988). Clinicans can agree in assessing relationship patterns in psychotherapy: The Core Conflictual Relationship Theme method. *Archives of General Psychiatry, 45*, 1001-1004.

DeRubeis, R. J., & Feeley, M. (1991). Determinants of change in cognitive therapy for depression. *Cognitive Therapy and Research, 14*, 469-482.

Diguer, L., Lefebvre, R., Drapeau, M., Luborsky, L., Rousseau, J.-P., Hebert, E., Daoust, J.-P., Pelletier, S., Scullion, M., & Descoteaux, J. (2001). The core conflictual relationship theme of psychotic, borderline, and neurotic personality organizations. *Psychotherapy Research, 11*, 169-186.

Drapeau, M., DeRoten, Y., & Korner, A. C. (2004). An exploratory study of child molester's relationship patterns using the Core Conflictual Relationship Theme Method. *Journal of Interpersonal Violence, 19*, 2, 264-275.

Drapeau, M., & Perry, J. C. (2004). Childhood trauma and adult interpersonal functioning: a study using the Core Conflictual Relationship Theme Method (CCRT). *Child Abuse and Neglect, 28*, 1049-1066.

Dunkle, J. H., & Friedlander, M. L. (1996). Contribution of therapist experience and personal characteristics to the working alliance. *Journal of Counseling Psychology, 43*, 456-460.

Ekstrom, S. R. (2002). A cacophony of theories: Contributions towards a story-based understanding of analytic treatments. *Journal of Analytical Psychology, 47*, 339-358.

Elkin, I., Shea, M. T., Watkins, J. T., Imber, S, D., Stotsky, S. M., Collins, J. F., Glass, D.

R., Pilkonis, P. A., Leber, W. R., Docherty, J. P., Fiester, S. J., & Parloff, M. B. (1989). NIMH Treatment of Depression Collaborative Research Program: General effectiveness of treatments. *Archives of General Psychiatry, 46*, 971-983.

Elliott, R. (1985). Helpful and non helpful events in brief counseling interviews: An empirical taxonomy. *Journal of Counseling Psychology, 32*, 307-322.

Festinger, L. (1957). *A theory of cognitive dissonance.* Evanston, IL: Row, Peterson and Company

Field, A. (2005). *Discovering statistics using SPSS*, (2nd edition). Thousand Oaks, CA: Sage Publications.

Fitzpatrick, M., & Chamodraka, M. (submitted). Participant Critical Events: A multi-perspective method for identifying and isolating significant therapeutic incidents.

Fitzpatrick, M., Janzen, J., & Chamodraka, M., & Park, J. (2006). Critical incidents in the process of early alliance development: A qualitative study. *Psychotherapy Research, 16*, 4, 486-498.

Fonagy, P. (1999). Memory and therapeutic interaction. *International Journal of Psychoanalysis, 80*, 215-223.

Foreman, S. A. (1996). The significance of turning passive into active in control mastery theory. *Journal of Psychotherapy Practice and Research, 5*, 2, 106-121.

Frances, A. (1996). Foreword in L. S. Benjamin's *Interpersonal diagnosis and treatment of personality disorders*, 2nd ed. The Guilford Press: New York.

Freeman, A., Pretzer, J., Fleming, B., & Simon, K. M. (1990) *Clinical applications of cognitive therapy*, New York: Plenum Press.

Fried, D., Crits-Christoph, P., &Luborsky, L. (1992). The first empirical demonstration of

transference in psychotherapy. *Journal of Nervous and Mental Disease, 180*, 5, 326-331.

Freud, S. (1909). *Five lectures on psychoanalysis*, Standard Edition 11, London: Hogarth Press.

Freud, S. (1958). The dynamics of transference. In J. Strachey (Ed. And Trans.), *The standard edition of the complete psychological works of Sigmund Freud* (Vol. 12, pp. 97-108). London: Hogarth Press (Original work published in 1912)

Freud, A. (1990). Transference. In A. H. Esman (Ed.), *Essential papers on transference*. New York: New York University Press. (original work published in 1936).

Gabbard, G. O. (2002). Developments in cognitive neuroscience: II. Implications for theories of transference. *Journal of the American Psychoanalytic Association, 50*, 1, 99-134

Gabbard, G. O. (2006). A neuroscience perspective on transference. *Psychiatric Annals, 36*, 4, 282-288.

Gaston, L., Goldfried, M. R., Greenberg, L. S., Horvath, A. O., Raue, P. J., & Watson, J. (1995). The therapeutic alliance in psychodynamic, cognitive-behavioral, and experiential therapies. Journal of Psychotherapy Integration, 5, 1, 1-26.

Gelso, C. J., & Carter, J. A. (1994). Components of the psychotherapy relationship: Their interaction and unfolding during treatment. *Journal of Counseling Psychology, 41*, 3, 296-306.

Gelso, C. J., Hill, C. E., & Kivlighan, D. M.(1991). Transference, insight, and the counselor's intentions during a counseling hour. *Journal of Counseling and Development, 69*, 428-433.

Gelso, C. J., & Hayes, J. A. (1998). *The psychotherapy relationship.* New York: Wiley

Gelso, C. J., Hill, C. E., Mohr, J. J., Rochlen, A. B., & Zack, J. (1999). Describing the face of transference: Psychodynamic therapists' recollections about transference in cases of successful long-term therapy. *Journal of Counseling Psychology, 46,* 257-267.

Gendlin, E. T. (1986). What comes after traditional psychotherapy research? *American Psychologist, 41,* 2, 131-136.

Goldfried, M. R. (1991). Transtheoretical ingredients in therapeutic change. In R. C. Curtis & G. Stricker (Eds), *How people change: Inside and outside therapy,* (pp. 29-37). New York, NY: Plenum Press.

Goldried, M. R. (2000). Consensus in psychotherapy research and practice: Where have all the findings gone? *Psychotherapy Research, 10,* 1, 1-16.

Goldstein, W. N., & Goldberg, S. T. (2004). *Using the transference in psychotherapy.* Lanham, MD: Oxford Press.

Greenberg, L. S. (1986). Change process research. *Journal of Consulting and Clinical Psychology, 54,* 4-9.

Greenberg, L. S., Rice, L. N., &Elliot, R. (1993). *Facilitating emotional change: The moment by moment process.* New York: Guilford Press.

Grencavage, L. M., & Norcross, J. C. (1990). Where are the commonalities among the therapeutic common factors? *Professional Psychology: Research and Practice, 5,* 372-378.

Grenyer, B. F. & Luborsky, L. (1996). Dynamic change in psychotherapy: Mastery of

interpersonal conflicts. *Journal of Consulting and Clinical Psychology, 64*, 2, 411-416.

Grenyer, B. F. & Luborsky, L. (1998). Positive versus negative CCRT patterns. In L. Luborsky and P. Crits-Christoph (Eds.) *Understanding Transference: The Core Conflictual Relationship Theme method.* (2nd ed.). (pp. 55-63). Washington DC: American Psychological Association.

Griffin, D. W., & Bartholomew, K. (1994). The metaphysics of measurement: The case of adult attachment. In K. Bartholomew & D. Perlman (Eds.), Attachment processes in adulthood. *Advances in Personal Relationships, 5*, 17-52. Bristol, PA: Jessica Kingsley Publishers.

Guadagnoli, E., & Velicer, W. F. (1988). Relation of sample size to the stability of component patterns. *Psychological Bulletin, 103*, 2, 265-275.

Hamilton, M. A. (1960). A rating scale for depression. *Journal of Neurological and Neurosurgical Psychiatry, 23*, 56-62.

Heppner, P. P., Kivlighan, D. M., & Wampold, B. E. (1999). *Research design in counseling* (2nd ed.). Belmont, CA: Wadsworth Publishing Company.

Hill, C. E. (1982). Counseling process researcher: Philosophical and methodological dilemmas. *The Counseling Psychologist, 10*, 4, 7-20.

Hill, C. E. (1990). Exploratory in-session process research in individual psychotherapy: A review. *Journal of Consulting and Clinical Psychology, 58*, 288-294.

Hill, C. E., & Corbett, M. M. (1993). A perspective on the history of process and outcome research in counseling psychology. *Journal of Counseling Psychology, 40*, 3-24.

Hill, C. E., Helms, J. E., Tichenor, V., Spiegel, S., B. O'Grady, K. E., & Perry, E. S. (1988). Effects of therapist response modes in brief psychotherapy. *Journal of Counseling Psychology, 35*, 222-233.

Hill, C. E., Nutt-Williams, E., Thompson, B., & Rhodes, R. H. (1996). Therapist retrospective recall of impasses in long-term psychotherapy: A qualitative analysis. *Journal of Counseling Psychology, 43*, 2, 207-217.

Hinkley, K., & Ansersen, S. M. (1996). The working self-concept in transference: Significant-other activation and self-change. *Journal of Personality and Social Psychology, 71*, 1279-1295.

Heppner, P. P., Kivlighan, D. M., & Wampold, B. E. (1999). *Research design in counselling*, (2nd ed.). Belmont, CA: Wadsworth Publishing Company.

Hoglend, P. (1993). Suitability for brief dynamic psychotherapy: psychodynamic variables as predictors of outcome. *Acta Paychiatr Scand, 88*, 104-110.

Hollon, S. D., & Kriss, M. R. (1984). Cognitive factors in clinical research and practice. *Clinical Psychology Review, 4*, 1, 35-76.

Horney, K. (1939). *New ways in psychoanalysis.* New York: Norton

Horowitz, M. J. (1989). Relationship schema formulation: Role relationship models and intrapsychic conflict. *Psychiatry, 52*, 260-274.

Horowitz, M. J. (1994). Configurational analysis and the use of relationship models to understand transference. *Psychotherapy Research, 4*, 184-196.

Horowitz, M. J., Merluzzi, T. V., Ewert, M., Ghannam, J. H., Hartley, D., & Stinson, C. H. (1991). Role-relationship models configuration. In M. J. Horowitz (Ed.),

Person schemas and maladaptive interpersonal patterns (pp. 115-154). Chicago: University of Chicago Press.

Horvath, A. O., & Bedi, R. P. (2002). The alliance. In: *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* J. C. Norcross (Ed.). New York, NY: Oxford University Press, 37-69.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the Working Alliance Inventory. *Journal of Counseling Psychology, 36*, 223-233.

Horvath, A. O., & Greenberg, L. S. (Eds.) (1994). *The working alliance: Theory, research, and practice.* New York: John Wiley & Sons. pp. 1-9.

Horvath, A. O., & Luborsky, L. (1993). The role of the therapeutic alliance in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 4, 561-573.

Horvath, A. O., & Symonds, D. (1991). Relationship between working alliance and outcome in psychotherapy: A meta-analysis. *Journal of Counseling Psychology, 38*, 139-149.

Howard, K. I., Kopta, S. M., Krause, M. S., & Orlinsky, D. E. (1986). The dose-effect relationship in psychotherapy. *American Psychologist, 41*, 2, 159-164.

Hunsley, J., Lee, C. M., & Aubry, T. (1999). Who uses psychological services in Canada?, *Canadian Psychology, 40*, 3, 1-13.

Imber, S. D., Pilkonis, P. A., Stotsky, S. M., Elkin, I., Watkins, J. T., Collins, J. F., Shea, M. T., Leber, W. R., & Glass, D. R. (1990). Mode-specific effects among three treatments for depression. *Journal of Consulting and Clinical Psychology, 58*, 352-359.

Kadera, S. W., Lambert, M. J., & Andrews, A. A. (1996). How much therapy is really enough? A session-by-session analysis of the psychotherapy dose-effect relationship. *Journal of Psychotherapy Practice & Research, 5*, 2, 132-151.

Joyce, A. S., & McCallum, M. (2004). Assessing patient capacities for therapy: Psychological-mindedness and quality of object relations. In D. P. Charman (Ed). *Core processes in brief psychodynamic psychotherapy: Advancing effective practice*, pp. 69-100) Mahwah, NJ: Lawrence Erlbaum Associates.

Juni, S. (1995). Triangulation as splitting in the service of ambivalence. *Current Psychology, 14*, 2, 91-112.

Kaiser, H. F. (1960). The application of electronic computers to factor analysis. *Educational and Psychological Measurement, 20*, 141-151.

Kelly, G. A. (1955). *The psychology of personal constructs* (Vol. 1). New York: Norton.

Kendall, P.C. & Bemis, K. M. (1983). Thought and action in psychotherapy: The cognitive-behavioral approaches. In M. Hersen, A. E. Kazdin, A. S. Bellack, (Eds.), *The clinical psychology handbook.* New York: Pergamon.

Kernberg, O. F. (1987). An ego psychology- object relations theory approach to the transference, *Psychoanalytic Quarterly, 56*, 197-221.

Kiesler, D. J., & Schmidt, J. A. (1993). *The Impact Message Inventory: Form IIA Octant Scale Version.* Palo Alto, CA: Mind Garden

Kirschenbaum, H. (2005). The current status of Carl Rogers and the person-centered approach. *Psychotherapy: Theory, research, practice, training, 42*, 1, 37-51.

Kivlighan, D., Patton, M. J., & Foote, D. (1998). Moderating effects of client attachment on the counselor experience-working alliance relationship. *Journal of Counseling Psychology, 45*, 3, 274-278.

Klein, M. (1975). Notes on some schizoid mechanisms. In *Envy and gratitude and other works,* 1946-1963 (pp.24-42). New York: Delacorte. (Original work published in 1946)

Kohut, H. (1968). The psychoanalytic treatment of narcissistic personality disorders: Outline of a systematic approach. *Psychoanalytic Study of the Child, 23*, 86-113.

Kokotovic, A. M., & Tracey, T. J. (1990). Working alliance in the early phase of counselling. *Journal of Counseling Psychology, 37*, 16-21.

Lambert, M. J. (1992). Implications of outcome research for psychotherapy integration. In J. C. Norcross & M. R. Goldfried (Eds.), *Handbook of psychotherapy integration* (pp. 94-129). New York: Basic Books.

Lambert, M. J. (2005). Early response in psychotherapy: Further evidence for the importance of common factors rather than "placebo effects". *Journal of Clinical Psychology, 61*, 7, 855-869.

Lambert, M. J., & Bergin, A. E. (1994) The effectiveness of psychotherapy. In A. E. Bergin & S. L. Garfield (Eds), *Handbook of psychotherapy and behavior change* (4th ed.), (pp. 143-189). Oxford, England: John Wiley & Sons.

Lambert, M. J., Hatch, D. R., Kingston, M. D., Edwards, Byron, C. Z., & Beck, A. T. (1986). Hamilton Rating Scales as measures of treatment outcome: A meta-analytic comparison. *Journal of Consulting and Clinical Psychology, 54*, 1, 54-59.

Lambert, M. J. & Ogles, B. M. (2004). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Bergin & Garfield's Handbook of psychotherapy and behavior change* (5th ed.), (pp. 139-193). New York: Wiley.

Landis, J., & Koch. G. (1970). The measurement of observer agreement for categorical data. *Biometrics, 33*, 159-174.

Leising, D., Rudolf, G., Stadler, K., Jakobsen, T., Oberbracht, C., & Grande, T. (2003). Do interpersonal behavior and emotional experience change in the course of successful long-term psychoanalytic therapies? *Psychotherapy Research, 13*, 461-474.

Levine, F. J., & Luborsky, L. (1981). The Core Conflictual Relationship Theme Method: A demonstration of reliable clinical inferences by the method of mismatched cases. In S. Tuttmen, C. Kaye, and M. Zimmerman (Eds.), *Object and self: A developmental approach.* New York: International Universities Press.

Luborsky, L. (1976). Helping alliances in psychotherapy: The groundwork for a study of their relationship to its outcome. In J. Claghorn (Ed.), *Successful psychotherapy* (pp. 92-116). New York: Brunner/Mazel

Luborsky, L. (1977). Measuring a pervasive psychic structure in psychotherapy: The Core Conflictual Relationship Theme. In N. Freedman & S. Grand (Eds.), *Communicative structures and psychic structures* (pp. 367-395), New York: Plenum Press.

Luborsky, L. (1985). *A dictionary of standard categories for the CCRT.* Edition I. Unpublished Manuscript.

Luborsky, L. (1998). Why each CCRt procedure was chosen. In L. Luborsky and P.

Crits-Christoph (Eds.) *Understanding Transference: The Core Conflictual Relationship Theme method.* (2nd ed.). (pp. 121-132). Washington DC: American Psychological Association.

Luborsky, L. (1990). The relationship anecdotes paradigm interview as a versatile source of narratives. In L. Luborsky & P. Crits-Christoph (Eds.), *Understanding transference: The core conflictual relationship theme method* (pp. 102-113). New York: Basic Books.

Luborsky, L. (1998). Alternative measures of the central relationship pattern. In L. Luborsky & P. Crits-Christoph (Eds.), *Understanding transference: The core conflictual relationship theme method* (pp. 289-304). (2nd ed.) New York: Basic Books.

Luborsky, L. & Bachrach, H. M. (1974). Factors influencing clinician's judgments of mental health: Experiences with the Health-Sickness Rating Scale. *Archives of General Psychiatry, 31*, 292-299.

Luborsky, L., Barber, J. P., & Beutler, L. (1993). Introduction to special section: A briefing on curative factors in dynamic psychotherapy. *Journal of Consulting and Clinical Psychology, 61*, 539-541.

Luborsky, L., Barber, P., & Diguer, L. (1992). The meanings of narratives told during psychotherapy: The fruits of a new observational unit. *Psychotherapy Research, 2*, 4, 277-290.

Luborsky, L., Barber, J. P., Schaffler, P., & Cacciola, J. (1998). The narratives told during psychotherapy and the types of CCRT's within them. In L. Luborsky and P. Crits-Christoph (Eds.) *Understanding Transference: The Core Conflictual*

Relationship Theme method. (2nd ed.). (pp. 135-150). Washington DC: American Psychological Association

Luborsky, L., & Crits-Christoph, P. (1988). Measures of psychoanalytic concepts: The last decade of research from "the Penn studies". *International Journal of Psycho-Analysis, 69*, 1, 75-86.

Luborsky, L., & Crits-Christoph, P. (1990). *Understanding Transference: The Core Conflictual Relationship Theme method.* New York: Basic Books.

Luborsky, L., & Crits-Christoph, P. (1998). *Understanding Transference: The Core Conflictual Relationship Theme method.* (2nd ed.). Washington DC: American Psychological Association.

Luborsky, L., Crits-Christoph, P., & Mellon, J. (1986). Advent of objective measures of the transference concept. Special Issue: Psychotherapy Research. *Journal of Consulting and Clinical Psychology, 54*, 39-47.

Luborsky, L., Crits-Christoph, P., Mintz, J., & Auerbach, A. (1988). *Who will benefit from psychotherapy?: Predicting therapeutic outcomes.* New York, NY: Basic Books.

Luborsky, L. & Diguer, L. (1998). The reliability of the CCRT measure: Results from eight samples. In L. Luborskky and P. Crits-Christoph (Eds.), *Understanding Transference: The Core Conflictual Relationship Theme Method* (2nd ed.). Washington DC: American Psychological Association.

Luborsky, L., Diguer, L., Andrusyna, T., Friedman, S., Tarca, C., Popp, C. A., Ermold, J., & Silberschatz, G. (2004). A method of choosing CCRT scorers. *Psychotherapy Research, 14*, 127-134.

Luborsky, L., Diguer, L., Kachele, H., Dahlbender, R., Waldinger, R., Freni, S., Krause, R., Frevert, G., Bucci, W., Drouin, M-S., Fischmann, T., Seganti, A., Wischmann, T., Hori, S., Azzone, P., Pokrony, D., Sattats, H., Zobel, H., Grenyer, B., Soldz, S., Anstadt, T., Schauenburg, H., Benninghoven, D. Stigler, M., & Tchesnova, I. (1999). A guide to the CCRT's methods, discoveries and future [On-line]. Accessed February 20, 2003. Available: http://sip.medizin.uni-ulm.de/abteilung/projekte/CCRT/ccrtmain.html.

Luborsky, L. & Luborsky, E. (1995). The era of measures of transference: The CCRT and other measures. In T. Shapiro & R. N. Emde (Eds.). *Research in psychoanalysis: Process, development, outcome*. Connecticut: International Universities Press Inc.

Luborsky, L., Mellon, J., van Ravenswaay, P., Childress, A. R., Cohen, K. D., Hole, A. V., Ming, S., Crits-Christoph, P., Levine, F. J., & Alexander, K. (1985). A verification of Freud's grandest clinical hypothesis: The transference. *Clinical Psychology Review, 5*, 231-246.

Luborsky, L., McLellan, A. T., Woody, G. E., O'Brien, C. P., & Auerbach, A. (1985). Therapist success and its determinants. *Archives of General Psychiatry, 42*, 602-611.

Luborsky, L., Popp, C., & Barber, J. P. (1994). Common and special factors in different transference-related measures. *Psychotherapy Research, 4*, 277-286.

MacCallum, R. C., Widaman, K. F., Zhang, S., & Hong, S. (1999). Sample size in factor analysis. *Psychological Methods, 4*, 84-99.

MacCallum, R. C., Widaman, K. F., Preacher, K. J., & Hong, S. (2001). Sample size in factor analysis: The role of model error. *Multivariate Behavioral Research, 36*, 611-637.

Marmar, C. R., Weiss, D. S., & Gaston, L. (1989). Toward the validation of the California Therapeutic Alliance Rating System. *Psychological Assessment, 1*, 46-52.

Martin, D. J., Garske, J. P., & Davis, M. K. (2000). Relation of therapeutic alliance with outcome and other variables: A meta-analytic review. *Journal of Consulting and Clinical Psychology, 68*, 438-450.

Meissner, W. W. (2001). A note on transference and alliance: II. Patterns of interaction. *Bulletin of the Menninger Clinic, 65*, 2, 219-245.

Mermelstein, J. J (2000). The role of concordance and complementarity in psychoanalytic treatment. *Psychoanalytic Psychology, 17*, 4, 706-729.

Meyer, B., Pilkonis, P.A., Proietti, J. M., Heape, C. L., & Egan, M. (2001). Adult attachment styles, personality disorders, and response to treatment. *Journal of Personality Disorders, 15*, 371-389.

Moras, K. & Strupp, H. H. (1982). Pretherapy interpersonal relations, client's alliance, and outcome in brief therapy. *Archives of General Psychiatry, 39*, 405-409.

Newman, M. G., Castonguay, L. G., Borkovec, T. D., & Molnar, C. (2004). Integrative Psychotherapy. In R. G. Heimberg, C. L. Turk, & D. S. Mennin (Eds), *Generalized anxiety disorder: Advances in research and practice* (pp. 320-350). New York, NY: Guilford Press.

Nicholson, R. A., & Berman, J. S. (1983). Is follow-up necessary in evaluating

psychotherapy? *Psychological Bulletin, 93*, 261-278.

Operationalized Psychodynamic Diagnostics Task Force (2001). *Operationalized psychodynamic diagnostics. Foundations and manual.* Seattle: Hogrefe & Huber.

Paivio, S. C., & Bahr, L. M. (1998). Interpersonal problems, working alliance, and outcome in short-term experiential therapy. *Psychotherapy Research, 8*, 392-407.

Piper, W. E., Azim, H. F. A., Joyce, A. S., & McCallum, M. (1991). Transference interpretations, therapeutic alliance, and outcome in short-term individual psychotherapy. *Archives of General Psychiatry, 48*, 946-953.

Popp, C. A., Luborsky, L., Andusyna, T. P., Cotsonis, G., & Seligman, D. (2002). Relationships between God and people in the bible: A core conflictual relationship theme study of the Pentateuch/Torah. *Psychiatry, 65*, 179-196.

Racker, H. (1968). *Transference and countertransference*. New York: Internaltional Universities Press.

Reisner, A. D. (2005). The common factors, empirically validated treatments, and recovery models of therapeutic change. *Psychological Record, 55*, 3, 377-399.

Rozin, P., & Royzman, E. B. (2001). Negativity bias, negativity dominance, and contagion. *Personality and Social Psychology Review, 5*, 296 – 320.

Safran, J. D., Muran, J. C., Samstag, L., & Wallner. (1994). Resolving therapeutic alliance ruptures: A task analytic investigation. In A. O. Horvath, L. S.Greenberg (Eds), *The working alliance: Theory, research, and practice* (pp. 225-255). Oxford, England: John Wiley & Sons.

Safran, J. D., & Segal, S. V. (1990). *Interpersonal process in cognitive therapy*. New York: Basic Books.

Samstag, L. W., Muran, J. C., & Safran, J. D. (2004). Defining and identifying alliance ruptures. In D. P. Charman (Ed) *Core processes in brief psychodynamic psychotherapy: Advancing effective practice. (pp. 187-214).* Mahwah, NJ, US: Lawrence Erlbaum Associates.

Schacht, T. & Binder, J. (1982). Focusing: A manual for identifying a circumscribed area of work for time-limited dynamic psychotherapy (TLDP). Unpublished Manuscript, Vanderbilt University.

Schacht, T. B., Binder, J., & Strupp, H. H. (1984). The dynamic focus. In H. Strupp & J. Binder, *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy* (pp. 65-109). New York: Basic Books.

Schacht, T. E., & Henry, W. P. (1994). Modeling recurrent patterns of interpersonal relationship with structural equation analysis of social behavior. The SASB-CMP. *Psychotherapy Research, 4*, 208-221.

Schneider, J. A. (2003). Working with pathological and healthy forms of splitting: A case study. *Bulletin of the Menninger Clinic, 67*, 1, 32-49.

Seganti, A. (1995). Detecting the negative expectation's structure in the "worst ending episodes" and measuring its defensive anticipation in the "best ending episodes". Paper presented at the Ulm CCRT celebration, April, 1995. (Ulm).

Seligman, M. E. P. (1998). Foreword in L. Luborsky and P. Crits-Christoph *Understanding Transference*, 2nd ed. Washington DC: American Psychological Association.

Sexton, H. C., Hembre, K., & Kvarme, G. (1996). The interaction of the alliance and therapy microprocesses: A sequential analysis. *Journal of Consulting and Clinical Psychology, 64*, 3, 471-480.

Shrout, P. E., & Fleiss, J. L. (1979). Intraclas correlations: Uses in assessing rater reliability. *Psychological Bulletin, 86*, 420-428.

Smith, M. L., Glass, G. V., & Miller, T. I. (1980). *The benefits of psychotherapy*. Baltimore: Johns Hopkins University Press.

Soldz, S. (1993). Beyond interpretation: The elaboration of transference in personal construct therapy. In L. Leitner & N. Dunnett (Eds.), *Critical issues in personal construct psychotherapy* (pp. 173-192). Malabar, FL: Robert E. Krieger

Stalker, C. A., Gebotys, R., & Harper, K. (2005). Insecure attachment as a predictor of outcome following inpatient trauma treatment for women survivors of childhood abuse. *Bulletin of The Menninger Clinic, 69*, 2, 137-156.

Stasch, M., Cierpka, M., Hillenbrand, E., & Schmal, H. (2002). Assessing reenactment in inpatient psychodynamic therapy. *Psychotherapy Research, 12*, 355-368.

Stevens, J. (1996). *Applied multivariate statistics for the applied social sciences*, (3rd ed.). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Stiles, W. B., Shapiro, D. A., & Elliott, R. (1986). "Are all psychotherapies equivalent?" *American Psychologist, 41,* 2, 165-180.Stevens, J. (1996). *Applied multivariate statistics for the applied social sciences*, (3rd ed.). Mahwah, NJ: Lawrence Erlbaum Associates, Publishers.

Strupp, H. H. (1980). Success and failure in time-limited psychotherapy. *Archives of General Psychiatry, 37*, 595-603.

Strupp, H. H., & Binder, J. L. (1984). *Psychotherapy in a new key: A guide to time-limited dynamic psychotherapy.* New York: Basic Books.

Sullivan, H. S. (1953). *The interpersonal theory of psychiatry.* New York: Norton.

Tellides, C., Fitzpatrick, M., Drapeau, M., & Bracewell, R., Janzen, J., & Jaouich, A. (2006). *The manifestation of transference in the formation of the therapeutic relationship: Study of a high-functioning population.* Unpublished manuscript. McGill University, Montreal, Quebec.

Tomkins, S. (1979). Script theory: Differential magnification of affects. In H. E. Howe, Jr., & R. A. Diensbier (Eds.), *Nebraska symposium on motivation* (Vol. 26, pp. 201-236). Lincoln: University of Nebraska Press.

Vanheule, S, Desmet, M., Rosseel, Y., & Meganck, R. (2006). Core transference themes in depression. *Journal of Affective Disorders, 91*, 1, 71-75.

Waldinger, R. J., Diguer, L., Guastella, F., Lefebvre, R., Allen, J. P., Luborsky, L., & Hauser, S. T. (2002). The same old song?—Stability and change in relationship schemas from adolescence to young adulthood. *Journal of Youth and Adolescence, 31*, 17-29.

Waldinger, R. J., Toth, S. L., & Gerber, A. (2001). Maltreatment and internal representations of relationships: Core relationship themes in the narratives of abused and neglected preschoolers. *Social Development, 10*, 41-48.

Wampold, B. E. (2001). *The great psychotherapy debate: Models, methods, and findings.* Mahwah, NJ: Lawrence Erlbaum Associates.

Weiss, J. (1994). The analyst's task: To help the patient carry out his plan. *Contemporary Psychoanalysis, 30*, 2, 236-254.

Weiss, J. & Sampson, H. (1986). *The psychoanalytic process: Theory, clinical observations and empirical research.* New York: Guilford Press.

Weiss, J., Sampson, H., Caston, J., & Silberschatz, G. (Eds.) (1977). *Research on the psychoanalytic process.* San Fransisco: Psychotherapy Research group, Department of Psychiatry, Mount Zion Hospital and Medical Center.

Westen, D. (1991). Social cognition and object relations. *Psychological Bulletin, 109,* 429-455.

Westen, D. (2000). *Psychotherapy Relationship Questionnaire (PRQ) Manual.* Available at http://www.psychsystems.net/lab.

Wilczec, A., Weinryb, R. M., Barber, J. P., Gustavsson, J. P., & Asberg, M. (2004). Change in the core conflictual relationship theme after long-term dynamic psychotherapy. *Psychotherapy Research, 14,* 1, 107-125.

Wilczec, A., Weinryb, R. M., Barber, J. P., Gustavsson, J. P., & Asberg, M. (2000). The core conflictual relationship theme (CCRT) and psychopathology in patients selected for dynamic psychotherapy. *Psychotherapy Research, 10,* 100-113.

Winnicott, D. W. (1956). On transference. *International Journal of Psychoanalysis, 37,* 386-388.

Wright, J. H. & Davis, D. (1994). The therapeutic relationship in cognitive-behavioral therapy: Patient perceptions and therapist responses. *Cognitive & Behavioral Practice, 1,* 1, 25-45.

Appendix A

CCRT Standard Categories (Edition 2) and Clusters

WISHES, NEEDS, INTENTIONS	RO	RS
1. To assert self & be independent	**1. Strong**	**1. Helpful**
21. to have self-control	24. are strong	7. am open
23. to be independent	23. are independent	1. understand
28. to be my own person	29. are happy	9. am helpful
2. To oppose, hurt & control others	**2. Controlling**	**2. Unreceptive**
16. to hurt others	20. are controlling	2. don't understand
18. to oppose others	26. are strict	8. am not open
19. to have control over others		6. dislike others
3. To be controlled, hurt and not responsible	**3. Upset**	**3. Respected & accepted**
15. to be hurt	16. are hurt	3. feel accepted
20. to be controlled by others	19. are out of control	4. feel respected
27. to be like others	22. are dependent	5. like others
	27. are angry	28. feel comfortable
	28. are anxious	29. feel happy
		30. feel loved
4. To be distant & avoid conflict	**4. Bad**	**4. Oppose & hurt others**
10. to be distant from others	8. are not trustworthy	10. hurt others
14. to not be hurt	15. are bad	11. oppose others
17. to avoid conflict		12. am controlling
29. to not be responsible or obligated		
5. To be close & accepting	**5. Rejecting and opposing**	**5. Self controlled and self-confident**
4. to accept others	2. are not understand	14. am self-controlled
5. to respect others	4. are rejecting	15. am independent
6. to have trust	6. don't respect me	18. feel self-confident
8. to be opened up to	7. don't trust me	
9. to be open	10. dislike me	
11. to be close to others	12. are distant	
	14. are unhelpful	
	15. hurt me	
	17. oppose me	
6. To be loved & understood	**6. Helpful**	**6. Helpless**
1. to be understood	13. are helpful	13. am out of control
2. to be accepted	18. are cooperative	16. am dependent
3. to be respected		17. am helpless
7. to be liked		19. am uncertain
33. to be loved		
13. to be helped		
35. to compete with someone for another person's affection		
7. To feel good & comfortable	**7. Likes me**	**7. Disappointed & depressed**
24. to feel good about myself	5. respect me	20. feel disappointed
30. to be stable	9. like me	21. feel angry
31. to feel comfortable	21. give me independence	22. feel depressed
32. to feel happy	30. loves me	23. feel unloved
		24. feel jealous
8. To achieve & help others	**8. Understanding**	**8. Anxious & ashamed**
12. to help others	1. are understanding	25. feel guilty
22. to achieve	3. are accepting	26. feel ashamed
25. to better myself	11. are open	27. feel anxious
26. to be g		31. somatic symptoms

Appendix B

PCE CLIENT INTERVIEW PROTOCOL
Oct 2002

INTRODUCTION

- Introducing yourself.
- Introduce the project we are working on - learning more about relationships between therapists and clients in therapy.
- Stress how important it is to know what clients think- not just what ***we*** think that they think about things.
- Talk about confidentiality.

RELATIONSHIPS IN GENERAL (warm-up phase)
HOW THEY GET STARTED

1. I would like you to think someone who is ***important*** to you with whom you have a good relationship. It could be a friend, your boyfriend, someone you know at school – anybody you have developed a relationship with. PAUSE For ***you***, what was that that started to get this relationship going on the right track?

OTHER'S PERSONALITY CHARACTERISTICS THAT INFLUENCE THEM

2. What are the things about the other person –that made a difference for you in whether the relationship started well?
3. Were there any things in the other person that actually got in the way of the relationship getting going?

SELF PERSONALITY CHARACTERISTICS THAT INFLUENCE RELATIONSHIPS

4. Are there things about you that you made the relationship start well?
5. Are there things about you that got in the way of the relationship starting well?

RELATIONSHIPS IN THERAPY (data phase)

6. Now I would like you to think particularly about counseling. Counseling is not necessarily the same as what we have been talking about. For instance, have you ever thought about there being a ***relationship*** between you and your therapist? Do you think it's ***important*** to have a relationship with him/her?

EXPECTATIONS

7. Before you started counseling, what did you think your relationship with your counselor would be like?

HOW THERAPEUTIC RELATIONSHIPS GET STARTED

8. What has been really important for you in getting your relationship with your counselor?

COUNSELOR PERSONALITY CHARACTERISTICS THAT INFLUENCE RELATIONSHIP DEVELOPMENT

9. Positive - Is there anything about your counselor that you think has helped the relationship to develop? *IF YOU GET A BEHAVIOR PROBE WITH "WHAT DOES THAT TELL YOU ABOUT HIM/HER?"*
10. Negative - Is there anything about your counselor that you think has gotten in the way of the relationship developing? *IF YOU GET A BEHAVIOR PROBE WITH "WHAT DOES THAT TELL YOU ABOUT HIM/HER?"*

SELF PERSONALITY CHARACTERISTICS THAT INFLUENCE THERAPEUTIC RELATIONSHIP DEVELOPMENT

11. Positive - Is there anything about you that you think has helped the relationship to develop? *IF YOU GET A BEHAVIOR PROBE WITH "WHAT DOES THAT MEAN ABOUT YOU?"*

12. Negative - Is there anything about you that you think has gotten in the way of the relationship developing? *IF YOU GET A BEHAVIOR PROBE WITH "WHAT DOES THAT MEAN ABOUT YOU?"*

DEFINING MOMENT IN RELATIONSHIP DEVELOPMENT

13. You are talking about (***summarize from question 8-how the relationship got started)***. Can you give me the best example, from your sessions so far of when this has happened?

14. Can you remember anything your counselor said or did – something we could see, that had an impact on what you have been describing?

15. Was there anything that you said or did – something we could see - that had an impact on what you have been talking about?

16. Was there anything that you thought or felt – something we couldn't see - that had an impact on what you have been talking about?

17. We're trying to actually find the place that you are describing to see if we can understand what it is that counselors do at these good times. Can you tell me in which session this incident happened? Can you tell me where in the session it happened? Can you tell me where in the session it happened? Do you remember what was happening just before and just after that?

WRAP UP RELATIONSHIP SECTION

18. Just before we finish talking about your relationship with your counselor, is there anything else that is important to you about the relationship that you have been thinking about that I haven't asked about yet?

CLIENT EXPERIENCING

19. In your sessions, can you tell me about a time so far when you have felt that you were more *"into it"*, I mean a sense that you were really involved in the session, that there was a lot of intensity, when you were really working and getting somewhere? What made the session come alive like that for you?

20. What were you doing saying at that time?

21. What was your counselor doing or saying at that time?

22. *GET A SESSION # and TIME IN THE SESSION.*

23. Was there anything about this moment that affected the relationship you have with your counselor?

CONCLUSION

24. PROCESSING - How did the interview go for you? (did they learn anything, say things that surprised them etc.). Are there any problems with the research so far?

THANKS

Thank them for participation not only in the interview but in the research in general. Emphasize how important it is to know the client's point of view.